75-1064

# In the Supreme Court of the United States

Supreme Court, U. S.
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No. A—

JACK B. KREMENS, Individually and as Hospital Director of Haverford State Hospital; FRANK S. BEAL, Individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; WILLIAM B. BEACH, JR., Individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,

Appellants

v.

KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND; Minors, Through Their Next Friend, Individually and on Behalf of All Others Similarly Situated,

Appellees

Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania

## JURISDICTIONAL STATEMENT

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## CITATION TO OPINION BELOW

The opinion of the lower court is reported at 402 F. Supp. 1039. The final order of the lower court is not published but is included in the Appendix at page 97a.

## STATEMENT OF JURISDICTION

This Court has jurisdiction over this appeal pursuant to 28 U.S.C. §1253 in that this appeal is taken from an order granting a permanent injunction in a civil action required to be tried by a district court of three judges. This appeal is timely in that this action was filed November 16, 1972, the decision of the three judge court was entered July 24, 1975, and the final order of the three-judge court was entered on November 17, 1975. This appeal was taken on November 28, 1975.



## CONSTITUTIONAL PROVISIONS INVOLVED

Eleventh Amendment to the Constitution of the United States:

> "The Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by Citizens of another State, or by Citizens or Subjects of any Foreign State."

Fourteenth Amendment to the Constitution of the United States, in pertinent part:

> "Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

## STATUTORY PROVISIONS INVOLVED

The Pennsylvania Mental Health and Mental Retardation Act of 1966, section 402 (Act of Oct. 20, 1966, Special Sess. No. 3, P. L. 96, art. IV, §402) is set forth as follows:

"(a) Application for voluntary admission to a facility for examination, treatment and care may be made by:

(1) Any person over eighteen years of age.

(2) A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.

(b) When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he may be admitted.

(c) Except where application for admission has been made under the provisions of section 402 (a) (2) and the person admitted is still eighteen years of age or younger, any person voluntarily admitted shall be free to withdraw at any time. Where application has been made under the provisions of section 402 (a) (2), only the applicant or his successor shall be free to withdraw the admitted person so long as the admitted person is eighteen years of age or younger.

(d) Each admission under the provisions of this section, shall be reviewed at least annually by a committee, appointed by the director from the professional staff of the facility wherein the person is admitted, to determine whether continued care is necessary. Said committee shall make written recommendations to the director which shall be filed at the facility and be open to inspection and review by the department and such other persons as the secretary by regulation may permit.

Where the admission is under the provisions of 402 (a) (2), the person admitted shall be informed at least each sixty days of the voluntary nature of his status at the facility."



The Pennsylvania Mental Health and Mental Retardation Act of 1966, section 403 (Act of Oct. 20, 1966, Special Sess. No. 3, P. L. 96, art. IV, §403) is set forth as follows:

"(a) Application for voluntary commitment to a facility for examination, treatment and care may be made by:

(1) Any person over eighteen years of age.

(2) A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.

(b) The application shall be in writing, signed by the applicant in the presence of at least one witness. When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he shall be committed for a period not to exceed thirty days. Successive applications for continued voluntary commitment may be made for successive periods not to exceed thirty days each, so long as care or observation is necessary.

(c) No person voluntarily committed shall be detained for more than ten days after he has given written notice to the director of his intention or desire to leave the facility, or after the applicant or his successor has given written notice of intention or desire to remove the detained person.

(d) Each commitment under the provisions of this section shall be reviewed at least annually by a committee, appointed by the director from the professional staff of the facility wherein the person is cared for, to determine whether continued care and commitment is necessary. Said committee shall make written recommendations to the director which shall be filed at the facility and be open to inspection and review by the department and such other persons as the secretary by regulation shall permit.

Where the commitment is under the provisions of section 403(a)(2), the person committed shall be informed at least each sixty days of the voluntary nature of his status at the facility."

The Pennsylvania Mental Health and Mental Retardation Act of 1966, section 426 (Act of Oct. 20, 1966, Special Sess. No. 3, P. L. 96, art. IV, §426) is set forth as follows:

"(a) Every person committed or detained in a facility by reason of the provisions of this act or anyone acting on his behalf, may at any time, petition for a writ of Habeas Corpus and, except as hereinafter provided, said petition shall be filed in accordance with the provisions of the act of May 25, 1951 (P. L. 415).

(b) Said petition may be based upon the following grounds:



(1) The insufficiency or illegality of the proceedings leading to such person's commitment, or,

(2) Although the commitment proceedings were proper, such person's continued detention or hospitalization is not warranted by reason of mental disability. Where the petition is based on this ground; (i) it shall be accompanied by the affidavit of a physician stating that he has examined the person and is of the opinion that such person is not mentally disabled, or that such mental disability does not require care or treatment in a facility, and (ii) the burden of proof shall rest upon the director responsible for such person's continued detention.

(c) Jurisdiction and venue is hereby conferred upon the several courts of the Commonwealth to issue writs of Habeas Corpus filed under this act as follows:

(1) A petition filed under section 426(b)(1) may be filed: (i) where committed by a court, only in the same court, or (ii) where committed under sections 404 or 405 of this act, only in the court of the county where the application for commitment was made.

(2) A petition filed under section 426(b)(2) may be filed: (i) in the court which committed such person or the court of common pleas of the county where he is detained if a civil commitment was ordered, or (ii) where a criminal charge is pending, in the court having jurisdiction of the charge or which committed him or the court of the county where he is detained, or (iii) where committed by a court where a criminal act was in any way otherwise involved in the proceedings leading to commitment, only in the same court which committed such person.

(3) If any petition under section 426(b)(2) is filed in a court other than the court of the county in which the person is detained, the petition may be transferred for disposition by the court in which it was filed to the appropriate court of the county in which the person is detained."

42 U.S.C. §1983 provides as follows:

"Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress."



## QUESTIONS PRESENTED

I. The lower court's holding that parents may not waive the constitutional rights of their juveniles is both novel and erroneous.

II. The retroactive injunctive relief granted by the lower court is improper.

III. The retroactive relief ordered by the three judge court below violates the Eleventh Amendment of the Constitution of the United States.

## STATEMENT OF THE CASE

On November 16, 1972 the plaintiffs instituted this civil rights action challenging the constitutionality of certain portions of Pennsylvania's Mental Health and Mental Retardation Act of 1966. Specifically the plaintiffs sought *inter alia* declaratory and injunctive relief from the operation of sections 402 and 403 of Pennsylvania's Mental Health and Mental Retardation Act [1] which generally provide the procedures for the admission and voluntary commitment of juveniles to Pennsylvania's Mental Health and Mental Retardation facilities.[2]

The plaintiffs in this class action were juveniles who had been placed in mental health facilities under the provisions of these statutes. These plaintiffs asserted that they were involuntarily admitted and committed at the hands of their parents or guardians pursuant to the above mentioned statutes and that such placement without *inter alia* a hearing violated their rights to equal protection and due process of law.

On February 13, 1973 a three-judge court was convened and after several hearings that court issued its opinion on July 24, 1975 wherein it found that sections 402 and 403 of the Act violated the due process clause of the Fourteenth Amendment. Specifically the Court

[1] These sections are set forth in full at pp. 4, 5 & 6 supra.

[2] Throughout the remainder of this Jurisdictional Statement mental health and mental retardation facilities will be referred to as simply "mental health facilities" and the Mental Health and Mental Retardation Act of 1966 will be referred to as "the Act".



found that parents could not constitutionally waive their children's due process rights in relation to the child's admission or commitment to a mental health facility (37a). In addition to declaratory relief the Court also granted extensive prospective and retroactive injunctive relief (97a-106a).

On November 28, 1975 this appeal was taken generally seeking review of both the lower court's findings and the nature of the relief ordered. After denial by the lower court this Court granted the appellants' request for a stay of the lower court's order on December 16, 1975.

## THE QUESTIONS ARE SUBSTANTIAL

### I. The Lower Court's Holding That Parents May Not Waive the Constitutional Rights of Their Juveniles Is Both Novel and Erroneous

The lower court made essentially three legal determinations which appellants presently seek review of by this Court. First it was determined that sections 402 and 403 of the Mental Health Act as well as the regulations promulgated thereunder, were facially unconstitutional on due process grounds.[3] Next the lower court found that parents and those standing in loco parentis could not effectively waive these due process rights of their children. And finally the Court prescribed an elaborate array of procedural rights which must be afforded in order to continue allowing admission or commitment of juveniles to the state's mental health facilities. The adverse effects of these erroneous findings stretch from the individual juvenile in need of care, through the family unit to various state mental health programs throughout the country.[4]

[3] These regulations are reproduced in the majority opinion at n. 5, pp. 25a-27a. See dissenting opinion of Broderick, J., pp. 52a-61a.

[4] The following state statutes permit parents to voluntarily commit their children to mental institutions: Alaska Stat. Sec. 47.30.020; A. R. S. (Ariz.) Secs. 36-502, 36-504; Ark. Stat. Ann. Sec. 59-405; Cal. Welf. & Inst. Code Sec. 6000; Colo. Rev. Stat. Ann. Sec. 71-1-2; 16 Del. C. Sec. 5121; D. C. Code Ann. Secs. 21-511, 21-512; Fla. S. A. Sec. 394, 465; Ga. Code Ann. Sec. 88-503.1; Hawaii R. S. Sec. 334-52; Idaho Code Ann. Secs. 66-318, 66-320; Ind. Stat. Ann. Sec. 22-1205; Ky. R. S. Sec. 202.015; 34 M. R. S. A. (Maine) Secs. 2291, 2293; Md. Ann. Code, Art. 59, Sec. 11(g); Mass. G. L. A. Ch. 123, Secs. 10, 11; Mich. C. L. A. Sec. 303.19a; Minn. Stat. Ann. Sec. 253A 03 subdiv. 1 and 2; V. A. M. S. (Missouri) Secs. 202.783, 202.790; Mont. Rev. Codes Ann. Sec. 38-406.2; Nev. R. S., Sec. 433.665; N. H. R. S. A. Secs. 135:22, 135:-22-a; N. J. S. A. Secs. 30:4-46, 30:4-48; N. M. Stat. Ann. Secs. 34-2-2, 34-2-4(2); N. Y. Mental Hygiene Law Sec. 71; N. D. Century Code Secs. 25.03-01, 20-03-06(2); Ohio Rev. Code Ann. Secs. 5122.02, 5122.03(A)(2); 43 Okl. St. Ann. Sec. 184; O. R. S. (Oregon) Sec. 426.220; Pa. Stat. Ann. tit. 50, Secs. 4402, 4403; S. C. Code Sec. 32-951; Tenn. Code Ann. Sec. 33-601; Utah Code Ann. Sec. 64-7-29; 18 V. S. A. (Vermont) Secs. 7503, 8001; Va. Code Ann. Sec. 37.1-65; R. C. W. A. (Washington) Secs. 72.23.-070, 72.23.090; W. Va. Code Ann. Secs. 27-4-1, 27-4-3; W. S. A. (Wisc.) Sec. 51.10; Sec. 25.54, W. S. (Wyoming).



The lower court's holdings regarding the due process rights of juveniles with respect to admission or commitment to a mental health facility is completely without precedent. This Court specifically excepted from its decision in *Wisconsin v. Yoder*, 406 U.S. 205, 230 (1972), any pronouncement on the proper balancing of the interests of the state, family, and juvenile member of the family when such interests potentially clash.[5]

The lower court's ruling mandates a complete adversary judicial proceeding before responsible parents can secure the professional care and treatment they deem necessary for their mentally handicapped children. Just

[5] The only authority remotely approaching the holding in this case counsel has been able to find are the unreported opinion in *Saville v. Treadway,* F. Supp. (C.A. 6969, M.D. Tenn. 1974); and *Horacek v. Exon,* 354 F. Supp. 71 (D. Neb. 1974). Both of these cases are equally lacking in precedent for their holding regarding the due process rights of juveniles and the waivability thereof by their parents.

as the right of parents to educate their children is fundamental and not lightly interfered with *Wisconsin v. Yoder,* supra. *Pierce v. Society of Sisters,* 268 U.S. 510 (1925), the rights of parents to freely provide medical treatment for their children cannot be overlooked as is required by the lower court's opinion and order.[6]

Assuming arguendo that some measure of due process must be provided, clearly the lower court has provided an "overdose" of such procedural requirements. As the dissent suggests this holding may well mark the beginning of the end of voluntary admission and commitment of juveniles for necessary care and treatment.[7] At what cost we must ask do we then surrender this valuable service? The lower court has mandated a severe intrusion by the state into the normal sphere of decision making authority reserved for the family.[8] And again we must ask at what cost? And finally at what cost do we permit an adversarial barrier of due process to be erected between the parent and child in need of care and treatment in a mental health facility.

Fundamental concepts of familial existence are involved in this case. In view of the tremendous impact of this decision, and in view of the fact that the resolution of this case will drastically effect thousands if not millions of families nationally it is strongly urged that this Court review the opinion in this case.

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[6] In *Stanley v. Illinois,* 405 U.S. 645, at 651 (1972) this Court found that "[t]he rights to conceive and to raise one's children have been deemed essential." See also *Meyer v. Nebraska,* 262 U.S. 390, 399 and *Skinner v. Oklahoma,* 316 U.S. 535 (1942).

[7] Dissent at 52a.

[8] L. Tribe, "Supreme Court—Forward: Toward a Model of Roles in Due Process," 87 Harv. L. Rev. (1973).



## II. The Retroactive Injunctive Relief Granted by the Lower Court Is Improper

The plaintiffs in this action were at all times attacking the very fact or duration of their confinement and they were seeking injunctive relief necessitating their immediate or speedier release.[9] In addition to the injunctive relief sought the plaintiffs requested damages and declaratory relief.[10]

The lower court, having found that Pennsylvania's Mental Health and Mental Retardation Act were facially unconstitutional on due process grounds, granted both declaratory and injunctive relief to the plaintiffs. As part of the injunctive relief it was ordered that the defendants were enjoined "to refrain from accepting or continuing the admission or commitment of any child . . ." who at that time was in, or was attempting to be admitted to, a mental health facility unless the child was provided the full panoply of prescribed due process rights within 120 days of the effective date of the Court's order.[11] In other words the lower court retroactively applied the injunctive aspects of its order which appellants contend is not permissible within the context of a civil rights action.

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[9] While the prayer for relief in the Complaint did not utilize the precise term "release" or some similar substitute therefore, the Complaint did request that the very statute which provided the sole basis by which the defendants were authorized to maintain custody of the plaintiffs be enjoined (16a). Further each of the named plaintiffs specifically complained of their—continued incarceration and set forth their desire to be released (6a-9a).

[10] (16a) Midway in the course of this litigation the plaintiffs relinquished their claims for damages.

[11] 103a-106a.

This Court has held in *Preiser v. Rodriguez*, 411 U.S. 475 (1972), that, to the extent that the remedy of habeas corpus may be available to protect the interests being advanced, that remedy must be utilized exclusively. As in *Preiser*, the plaintiffs in this action were clearly attacking the very basis of their custody, which attack this Court noted was "the essence of habeas corpus" *Id.* at 484.

However, in this case the plaintiffs also sought relief in the form of damages.[12] The question then arises whether or not claims for traditional habeas corpus relief can be resolved by federal courts ancillary to an apparent valid civil rights damage claim.

The answer which demonstrates the defect in the lower court's order in this case is found in the decision of this Court in *Wolff v. McDonnell*, 418 U.S. 539 (1973). In *Wolff* this Court held that a civil rights action for damages may provide the jurisdictional base for ancillary determination of claims for declaratory and injunctive relief which could have otherwise been obtained through habeas corpus. But, this Court noted very clearly that such injunctive relief may only be prospective in nature and then, as always, standing requirements must be met. The analogy being drawn and which is compelled by this Court's holding in *Wolff* is clear from the following language found, at pp. 554-5 of the opinion:

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[12] At p. 494 of *Preiser* this Court noted that "[I]f a state prisoner is seeking damages, he is attacking something other than the fact or length of his confinement, and he is seeking something other than immediate or more speedy release, the traditional purpose of habeas corpus. In the case of a damages claim, habeas corpus is *not* an appropriate or available federal remedy."



"At the threshold is the issue whether under Preiser v. Rodriguez, 411 U.S. 475 (1973), the validity of the procedures for depriving prisoners of good-time credits may be considered in a civil rights suit brought under 42 U.S.C. §1983. In Preiser, state prisoners brought a §1983 suit seeking an injunction to compel restoration of good-time credits. The Court held that because the state prisoners were challenging the very fact or duration of their confinement and were seeking a speedier release, their sole federal remedy was by writ of habeas corpus, 411 U.S. at 500, with the concomitant requirement of exhausting state remedies. But the Court was careful to point out that habeas corpus is not an appropriate or available remedy for damages claims, which, if not frivolous and of sufficient substance to invoke the jurisdiction of the federal court, could be pressed under §1983 along with suits challenging the conditions of confinement rather than the fact or length of custody. 411 U.S. at 494, 498-499.

The complaint in this case sought restoration of good-time credits, and the Court of Appeals correctly held this relief foreclosed under Preiser. But the complaint also sought damages; and Preiser expressly contemplated that claims properly brought under §1983 could go forward while actual restoration of good-time credits is sought in state proceedings. 411 U.S. at 499 n. 14. Respondent's damages claim was therefore properly before the District Court and required determination of the validity of the procedures employed for imposing sanctions, including loss of good time, for flagrant or serious misconduct. Such a declaratory judgment as a predicate to a dam-

ages award would not be barred by Preiser; and because under that case, only an injunction restoring good time improperly taken is foreclosed, *neither would it preclude a litigant with standing from obtaining by way of ancillary relief an otherwise proper injunction enjoining the prospective enforcement of invalid prison regulations.*

We therefore conclude that it was proper for the Court of Appeals and the District Court to determine the validity of the procedures for revoking good-time credits and to fashion appropriate remedies for any constitutional violations ascertained, short of ordering the actual restoration of good time already canceled." [Emphasis supplied.]

Thus even assuming there existed plaintiffs with proper standing to seek the prospective injunctive relief, which is not at all clear or conceded, it was clear error under *Wolff* for the lower court to order the retroactive application of the injunctive relief.

The effect of the error committed by the lower court will not be minimal. In fact this Court was required to intervene in this case and stay the operation of the order of this case.[13] The lower court in this matter without ever formally involving the Commonwealth judicial branch of government ordered that all children then in the custody of any mental health facility[14] must either be discharged or recommitted pursuant to the provisions of the lower

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[13] U.S. (December 15, 1975).

[14] The lower court's order presumably covers all Pennsylvania Mental Health facilities notwithstanding the fact that approximately 150 of these facilities are private and only licensed by the Commonwealth.



court's decree within 120 days of the date of the order. The adverse effect of this order on the judicial branch of Pennsylvania's government was pointed out as follows by Chief Justice Jones of the Pennsylvania Supreme Court in a telegram directed to each member of this Court.

"ORDER APPEALED FROM CALLS FOR JUDICIAL INTERVENTION IN ESTIMATED SIX TO EIGHT THOUSAND CASES WITHIN FIVE MONTHS.[15] COURT ADMINISTRATOR OF PENNSYLVANIA PREPARING, TO INTERVENE IN THE ACTION, IF POSSIBLE, AND HE AND THIS COURT JOIN WITH THE COMMONWEALTH IN THE REQUEST FOR A STAY. FAILURE OF STAY WILL RESULT IN OVERWHELMING AND DISRUPTING THE JUDICIAL SYSTEM OF PENNSYLVANIA WHICH ARE ALREADY OVERLOADED WITH REGULAR COURT BUSINESS".[16]

Of course, it is not only Pennsylvania's judicial system that will suffer as a result of the effect of the lower court's order.[17] This order if allowed to go into effect will greatly undermine the delicate balance of judicial authority which has been created in our federal system of

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[15] The lower court's order actually requires completion of these hearings within 120 days (105a).

[16] The Supreme Court of Pennsylvania has informed counsel for appellants that upon notation of jurisdiction in this matter its counsel Bernard G. Segal will seek to proceed as *amicus curiae*.

[17] This clash between the federal and state judicial systems would have in large part been avoided if the lower court had not completely ignored traditional notions of federalism. See *Rizzo v. Goode*, U.S. , 44 U.S.L.W. 4095 (Jan. 21, 1976).

government. It is thus absolutely essential that this Court hear this appeal and determine to what extent a federal court can create new causes of action and order massive numbers of state judicial proceedings in state courts. [18]

Finally, as has already been pointed out the vast majority of the states have similar juvenile admission and commitment statutes which, if not already under attack, will undoubtedly be the subject of similar attacks in this ever-burgeoning area of mental health litigation.[19] Further, it should be noted that there are many mental health cases presently pending which in one way or another challenge the fact or duration of confinement on due process grounds, which cases will most probably involve similar *Preiser* and *Wolff* problems if such issues have not already arisen.[20]

Pennsylvania law provides a complete remedy for mental patients to challenge the legality of their confinement.[21] And instead of ignoring the state's law the lower court should have required that presently incarcerated patients assert their newly pronounced rights to due process by this means rather than to completely disrupt the judicial system of Pennsylvania by creating new forms of

[18] Fortunately questions of enforcement of the lower court's order have not and will not arise until further action by this Court as a result of the stay issued previously by this Court.

[19] See note 4 supra.

[20] See e.g. *Kidd v. Schmidt*, C.A. No. 74-6605 (E.D. Wisc., 3 J. Ct. 1974); *J. L. & J. R. Minors v. Parham*, 75-163-MAC (M.D. Ga., 3 J. Ct. 1975); *Goldy v. Beal*, C. A. 74-400 (M.D. Pa. 3 J. Ct. 1974); *Wallace v. Chancery Clerk of Chicksaw County*, E. C. 75-92-S (N.D. Miss. 1974); *Dixon v. Weinberger*, C. A. 74-285 (D.D.C. 1974); *Poe v. Weinberger*, C. A. 74-1800 (D.D.C. 3 J. Ct. 1974).

[21] See 50 P.S. §4426 set forth in full at pp. 6-8 supra.



action and severe time restrictions upon the completion of this massive amount of litigation.[22]

Overstatement of the importance of the issues raised by the retroactive application of the lower court's order in this case is difficult to conceive. Paramount considerations of federalism were totally ignored by the lower court in framing its equitable relief. The importance of such considerations has recently been noted by this Court:

> "When the frame of reference moves from a unitary court system, governed by the principles just stated, to a system of federal courts representing the Nation, subsisting side by side with 50 state judicial, legislative, and executive branches, appropriate consideration must be given to principles of federalism in determining the availability and scope of equitable relief. Doran v. Salem Inn, Inc., 422 U.S. 922, 928 (1975)."
>
> *Rizzo v. Goode,* U.S. , 44 U.S.L.W. 4095, 4100.

## III. The Retroactive Relief Ordered by the Three-Judge Court Below Violates the Eleventh Amendment of the Constitution of the United States

The Eleventh Amendment of the Constitution of the United States has, since this Court's decision in *Hans v.*

[22] In this connection this Court is directed to the case of *Kendall v. True*, 391 F.S. 413 (W.D. Ky. 1975) where the Court properly refused to retroactively apply its injunctive order and required the then incarcerated patients to utilize the state remedies to pursue their release.

*Louisiana,* 134 U.S. 1 (1890), been held applicable to suits brought against an unconsenting state by a citizen of that same state. *Georgia Railroad & Banking Co. v. Redwine,* 342 U.S. 299 (1950); *Employees v. Department of Public Health & Welfare,* 411 U.S. 279 (1973).

Similarly, in determining the applicability of the Eleventh Amendment to a particular action, this Court has looked not only to the relief requested, *Larson v. Domestic & Foreign Commerce Corp.,* 337 U.S. 682 (1949), but also to the relief actually ordered. *Minnesota v. Hitchcock,* 185 U.S. 373 (1902).

Upon examination of the nature and effect of the relief mandated below, appellants assert that the retroactive requirements of the order, raise substantial and novel questions under the Eleventh Amendment. Specifically this Court is rquested to review the propriety of a federal court clearly requiring allocations from a state's treasury to retroactively implement newly announced due process commitment standards, and also requiring a state officer to affirmatively exercise powers of the sovereign.

Since *Ex parte Young,* 209 U.S. 123 (1908), there has been no doubt as to a federal court's authority to entertain a suit against a state official, acting or threatening to act, under a statute alleged to be unconstitutional:

> "If the act which the state attorney general seeks to enforce be a violation of the Federal Constitution, the officer in proceeding under such enactment comes into conflict with the superior authority of that Constitution, and he is in that case stripped of his official or representative character and is subjected in his person to the consequences of his individual conduct." *Id.* at 160.



Despite the doctrine of *Ex parte Young,* allowing a federal court to assert its jurisdiction over a state officer in his individual capacity, this Court has recognized certain limitations on the relief which may be afforded against the individual. As was stated in *Larson v. Domestic & Foreign Commerce Corp., supra:*

> "Of course, a suit may fail, as one against the sovereign, even if it is claimed that the officer being sued has acted unconstitutionally or beyond his statutory powers, if the relief requested cannot be granted by merely ordering the cessation of the conduct complained of but will require affirmative action by the sovereign or the disposition of unquestionably sovereign property. [Citation omitted]" *Id.* at 691 n. 11.

While *Larson* involved the federal government's sovereign immunity, the decision of this Court in *Edelman v. Jordan,* 415 U.S. 651 (1974), makes clear that relief requiring the disposition of unquestionably sovereign property, particularly monies from a state's treasury, is similarly barred by the Eleventh Amendment. Relying on *Ex parte Young,* this Court in *Edelman,* held that the retroactive award of wrongfully withheld AFDC benefits whether denominated as damages or equitable restitution, was barred by the Eleventh Amendment.

This Court's opinion in *Edelman* quotes with approval the words of Judge McGowen in *Rothstein v. Wyman,* 467 W. 2d 226 (2d Cir. 1972), where he observed that:

> "It is one thing to tell the Commissioner of Social Services that he must comply with the Federal standards for the future if the state is to have the bene-

fit of Federal funds in the programs he administers. It is quite another thing to order the Commissioner to use state funds to make reparation for the past. The latter would appear to us to fall afoul of the Eleventh Amendment if that basic constitutional provision is to be conceived of as having any present force." 467 F. 2d at 236-37 (footnote omitted).

While it may be argued in the present case that the expenditure of funds for the recommitment hearings and for the provision of counsel required by the order below, is not the same as the monetary award contemplated in *Edelman,* this Court clearly met that issue by focusing on the impropriety of requiring an *allocation* from the state treasury to meet the requirements of the order:

". . . where the state has a definable allocation to be used in the payment of public aid benefits, and pursues a certain course of action such as the processing of applications within certain time periods as did Illinois here, the subsequent ordering by a federal court of retroactive payments to correct delays in such processing will invariably mean there is less money available for payments for the continuing obligations of the public aid system." *Edelman,* 415 U.S. at 666 n. 11.

Similarly, Pennsylvania has already made an allocation for the representation of indigents as well as for the proceedings required under the various commitment sections of the Pennsylvania Mental Health and Mental Retardation Act. The order of the court below will necessarily mean that less money will be available to meet those already existing obligations.[23]

[23] Article 3, §24 of the Pennsylvania Constitution provides:



This Court in *Edelman* clearly found that retroactive relief requiring the direct payment of funds from the state treasury violated the Eleventh Amendment of the Constitution. This case raises the substantial question of whether the Eleventh Amendment is so transparent as to protect the sovereign states only from relief requiring direct payments of public funds or whether relief, non-monetary in nature, but still requiring vast expenditures of public funds is similarly prohibited.

This Court's opinion in *Larson, supra,* clearly suggests that the sovereign's immunity generally bars relief requiring a governmental officer to affirmatively exercise the powers of sovereign. *Hawaii v. Gordon,* 373 U.S. 57 (1963); *Dugan v. Rank,* 372 U.S. 609 (1963); *Malone v. Bowdoin,* 369 U.S. 643 (1962); *Land v. Dollar,* 330 U.S. 731 (1947); *Ex parte New York,* 256 U.S. 490 (1921).[24]

While this issue appears to be novel in its presentation to this Court, authorities since *Ex parte Young* lend

"No money shall be paid out of the treasury, except on appropriations made by law and on warrant issued by the proper officers; but cash refunds of taxes, licenses, fees, and other charges paid or collected, but not legally due, may be paid, as provided by law, without appropriation from the fund into which they were paid on warrant of the proper officer."

[24] While appellants have found no case in this Court which either affirmatively or negatively applies this proscription to cases involving the Eleventh Amendment a number of lower federal courts have discussed the issue. See *Ad Hoc Committee on Judicial Administration v. Massachusettes,* 488 F. 2d 1241 (1st Cir. 1973); *Frye v. Lukehard,* 364 F. Supp. 1379 (W.D. Va. 1973); *Parker v. Mandel,* 344 F. Supp. 1068 (D. Md. 1972); *James v. Almond,* 170 F. Supp. 331 (E.D. Va. 1959); *Kansas City Southern Railway Co. v. Morley,* 88 F. Supp. 300 (W.D. Ark. 1950).

credence to the Proposition that the Eleventh Amendment does bar injunctive relief which would require a state official to act affirmatively, at least when such actions would be required to retroactively remedy a previous denial of constitutional rights:

> "The general discretion regarding the enforcement of laws when and as he deems appropriate is not interfered with by an injunction which restrains the state officer from taking any steps towards the enforcement of an unconstitutional enactment to the injury of complainant. *In such case no affirmative action of any nature is directed, and the officer is simply prohibited from doing an act which he had no legal right to do.*" *Ex parte Young,* 209 U.S. at 159 (emphasis supplied).

It is true that this Court has required state officials to take affirmative steps to prospectively remedy unconstitutional procedures or situations.[25] *Griffin v. County School Board of Prince Edward County,* 377 U.S. 218 (1964); *Graham v. Richardson,* 403 U.S. 365 (1971); *Goldberg v. Kelly,* 397 U.S. 254 (1970). The orders in these cases are actually no different than the prospective aspect of *Edelman* which allows only "an ancillary effect on the state treasury". Thus, a federal court clearly may grant prospective injunctive relief to cure existing constitutional infirmities and such relief may, as an ancillary effect, impose some burden on officials of the sovereign to individually take appropriate affirmative actions.[26]

---

[25] See discussion of *Wolff v. McDonnell, supra.*

[26] In *Youngstown Sheet & Tube Co. v. Sawyer,* 343 U.S. 579 (1952), this Court upheld an injunction restraining the Secretary of Commerce from "continuing the seizure and possession of the plant." The injunction issued against a federal officer was by its language prospective in effect.



However, this Court has never sanctioned an injunction which would require a state officer in his official capacity, to take an affirmative act, retroactive in effect, in order to grant a newly pronounced right previously withheld. The court below requires precisely such sovereign acts in mandating the discharge or release of all previously committed juveniles.

It is therefore necessary that this Court note jurisdiction in this case to resolve the grave questions herein raised which are fundamental to the basic concepts of federalism embodied in our Constitution.

## CONCLUSION

Based upon the foregoing arguments and authorities it is requested that this Court note jurisdiction in this appeal, receive full briefs on the merits, and hear oral arguments in order to resolve the substantial questions which are involved.

(s) NORMAN J. WATKINS
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## IN THE SUPREME COURT OF THE UNITED STATES

No. A—

Jack B. Kremens, et al.,
Appellants

v.

Kevin Bartley, et al.,
Appellees

## CERTIFICATE OF SERVICE

I, NORMAN J. WATKINS, Deputy Attorney General, do hereby certify that I have served by United States Mail, postage prepaid, first class, on this date, Tuesday, January 27, 1976, three copies of Appellants' Jurisdictional Statement and Appendix to David Ferleger, Esquire, Counsel for Appellees, at 1315 Walnut Street, Suite 1600, Philadelphia, Pennsylvania 19103. I further certify that all parties required to be served in this appeal have been served.

(s) NORMAN J. WATKINS
NORMAN J. WATKINS
*Deputy Attorney General*

75-1064

# In the Supreme Court of the United States

Supreme Court, U. S.
FILED
JAN 27 1976
MICHAEL RODAK, JR., CLERK

No. A—

JACK B. KREMENS, Individually and as Hospital Director of Haverford State Hospital; FRANK S. BEAL, Individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; WILLIAM B. BEACH, JR., Individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,

Appellants

v.

KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND; Minors, Through Their Next Friend, Individually and on Behalf of All Others Similarly Situated,

Appellees

Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania

## APPENDIX TO JURISDICTIONAL STATEMENT

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## COMPLAINT—NOVEMBER 16, 1972

### IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Kevin Bartley; Steve Gentile; Leslie Levine; Vicki Mathews; Mark Weand, minors, through their next friend, individually and on behalf of all others similarly situated,

Plaintiffs

v.

Haverford State Hospital; Jack B. Kremens, individually and as Hospital Director of Haverford State Hospital; Helene Wohlgemuth, individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; William B. Beach, Jr., individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,

Defendants

### COMPLAINT—CLASS ACTION

### I.
### PRELIMINARY STATEMENT

1. Plaintiffs, individually and on behalf of all others similarly situated, seek declaratory and injunctive relief, and damages, for violations of their civil

rights resulting from the operation of certain parts of the Pennsylvania Mental Health and Mental Retardation Act of 1966 which permit the involuntary commitment of persons eighteen years of age or under to mental health facilities on a different basis than other persons and without notice, hearing, right to counsel and other procedural safeguards. The convening of a three judge court is also sought. The statutes are challenged on the grounds that they conflict with the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution.

## II.
## JURISDICTION

2. Jurisdiction is conferred upon this court by 28 U.S.C. § 1331 which provides for original federal question jurisdiction. The amount in controversy, exclusive of interest and costs, is greater than $10,000.

3. Jurisdiction is conferred upon this court by 28 U.S.C. § 1343(3) which provides for original jurisdiction in all suits authorized by 42 U.S.C. § 1983 to redress the deprivation under color of state law of any right, privilege or immunity secured by the Constitution of the United States and by federal law. Defendants here act under color of law.

4. Plaintiffs' action for declaratory and injunctive relief, and for damages, is authorized by:

a. 28 U.S.C. 2201, 2202, 2281 and 2284, and by Rules 57 and 65 of the Federal Rules of Civil Procedure, which relate to declaratory judgments, injunctions and three judge courts.



b. 42 U.S.C. §§ 1983 and 1988, which relate to civil rights actions.

## III.
## THREE-JUDGE COURT

5. This is a proper case for determination by a three-judge court pursuant to 28 U.S.C. §§ 2281 and 2284 since Plaintiffs seek an injunction to restrain Defendants, a state institution and state officers, from the enforcement, execution and operation of portions of state statutes (50 P.S. §§ 4402(a)(1), 4402(a)(2), 4402(c), 4403(a)(1), 4403(a)(2) and 4403(c)) of state-wide applicability on the ground that said statutes are contrary to the United States Constitution.

## IV.
## CLASS ACTION

6. The named Plaintiffs bring this action on their own behalf and, pursuant to Rule 23(a), 23(b)(2) of the Federal Rules of Civil Procedure, on behalf of all others similarly situated.

7. The members of the class of Plaintiffs similarly situated are all persons under eighteen years of age who have been, are, or may be admitted or committed to Haverford State Hospital and all other state mental health facilities under the challenged provisions of the state statute.

8. The requirements of Rule 23 are met in that: the class is so numerous that joinder of all members is impractical (and the total membership of the class is indeterminate); there are questions of law and fact common to the class; the claims of the representative parties are typical of the claims of the class; the representative parties will fairly and adequately protect the interests of the class; and the parties opposing the class have acted on grounds generally applicable to the class, thereby making appropriate final injunctive and declaratory relief with respect to the class as a whole.

9. Defendant Jack B. Kremens, Hospital Director of Defendant Haverford State Hospital, is sued as representative of the directors of all mental health facilities in Pennsylvania, all of which are under the authority and supervision and regulation of Defendants Wohlgemuth and Beach. All the allegations in Paragraph 8 above (with the exception of the last clause) are applicable here and are incorporated by reference.

10. The questions of law and fact involved are:

a. Are the representative parties, and their class, admitted or committed involuntarily to Defendant Haverford State Hospital and other mental health facilities pursuant to the challenged statutory provisions?

b. Do Defendants operate, execute and enforce the challenged statutes?

c. Are the challenged statutes contrary to the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution?



## V.
## PLAINTIFFS

11. Plaintiff Kevin Bartley is a citizen of Pennsylvania, age 16, having been born November 4, 1956.

12. Plaintiff Steve Gentile is a citizen of Pennsylvania, age 18, having been born March 20, 1954.

13. Plaintiff Leslie Levine is a citizen of Pennsylvania, age 15, having been born October 8, 1957.

14. Plaintiff Vicki Mathews is a citizen of Pennsylvania, age 15, having been born September 10, 1957.

15. Plaintiff Mark Weand is a citizen of Pennsylvania, age 15, having been born June 13, 1957.

16. All named Plaintiffs are being held at Defendant Haverford State Hospital against their will having been admitted or committed by Defendants or under their direction pursuant to the challenged sections of the Pennsylvania Mental Health and Mental Retardation Act of 1966. Such admissions and commitments were accomplished without notice, hearing, right to counsel or order of court.

## VI.
## DEFENDANTS

17. Defendant Haverford State Hospital is a mental health "facility" under Section 102 of the Pennsylvania Mental Health and Mental Retardation Act of 1966. It receives admissions and commitments of persons, including Plaintiffs and their class, under said act.

18. Defendant Jack B. Kremens is Hospital Director of Defendant Haverford State Hospital and is charged with supervision and administration of the facility. See Sections 102 and 203 of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (hereafter the "Act"). It is to Kremens or his delegate that applications for admission, commitment and release must be made. See Sections 402 (b), 403 (b) and 403 (c) of the Act.

19. Defendant Helene Wohlgemuth is the Secretary of Public Welfare of the Commonwealth of Pennsylvania which department has the power and duty to enforce the Act and all regulations necessary and appropriate to the proper accomplishment of the Act and to operate and assign functions to all state facilities. See Sections 201 (2) and 202 (a) of the Act.

20. Defendant William B. Beach, Jr. is the Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania. He has general authority to supervise and regulate mental health facilities within Pennsylvania.

---

## VII.

## FACTUAL ALLEGATIONS

---

*Kevin Bartley*

21. Plaintiff Kevin Bartley was committed to Haverford State Hospital on November 30, 1971 under Section 403 (a) (2) of the Act.



22. He was committed by his mother although he did not wish to enter the hospital then and does not wish to remain now. Kevin Bartley is critical of many of what he believes are the hospital's shortcomings: e.g., arbitrary regulations, the staff's playing favorites with patients, unnecessary punishments for minor rule infractions, and transfer to locked wards as punishment for mere allegations of wrongdoing, without hearing or proof.

23. Bartley believes that nothing worthwhile is occurring to him inside the hospital and that his time is mostly being wasted. This is true. When he obtains release, he plans to go to school and learn a usable trade.

*Steve Gentile*

24. Plaintiff Steve Gentile was committed to Haverford State Hospital on August 24, 1971 by his father under Section 403 (a) (2) of the Act.

25. Gentile entered the hospital involuntarily, is being detained there involuntarily and wishes to leave but is restrained from doing so by Defendants and the operation of the challenged portions of the Act.

*Leslie Levine*

26. Plaintiff Leslie Levine's mother committed her to Haverford State Hospital on October 11, 1972 under Section 403 (a) (2) of the Act.

27. Levine does not wish to remain at the hospital but is restrained from leaving by Defendants and by the operation of the challenged portions of the Act.

28. Levine was committed to the hospital because she does not get along with her mother and sister. Her parents are divorced; her father is remarried and living in Florida. Leslie Levine would like to be with her father; they get along well and, every time she spends some time with him, her behavior is excellent. However, because she is with her mother and sister and does not get along with them, Levine is an involuntary mental hospital patient.

*Vicki Mathews*

29. Plaintiff Vicki Mathews was committed to Haverford State Hospital on August 9, 1972 by her parents under Section 403 (a) (2) of the Act.

30. She entered the hospital involuntarily.

31. Mathews does not get along well with her parents and has in the past run away from home. If she were considered a "delinquent," and dealt with through the juvenile court process, she could not be institutionalized against her will except after a full hearing, upon order of a court. In fact, as the mental health commitment laws permit, her parents had the choice of avoiding the due process protections afforded juveniles in other contexts and of dealing with her in their own way, thus depriving Mathews of any hearing and committing her to a mental hospital.

32. Because her parents had the financial means, on information and belief, they applied for her discharge from the hospital under Section 403 (c) so that she could be shipped, against her will, to a boarding school in Texas.



*Mark Weand*

33. Plaintiff Mark Weand was admitted to Haverford State Hospital on June 23, 1972 by his mother under Section 402 (a) (2) of the Act.

34. After another hospital would not admit him because of his age, Weand first entered Haverford for medical reasons because of excess use of drugs. Once at the hospital, his mother was convinced by agents and employees of Defendants to have Weand admitted for psychiatric reasons. Weand did not wish to become a mental patient and repeatedly has informed Defendants' agent's and employees of his desire to leave. They have not permitted him to do so.

35. At the hospital, Weand has not been involved with any therapeutic drug programs because he has not been addicted to any drugs.

36. His mother is concerned about him but will not apply for his release except upon the approval of the hospital physicians, employees and agents of Defendants. If Weand were a voluntary patient under Section 402 of the Act and were over eighteen, he would be permitted to leave the hospital "at any time" regardless of the physicians' approval or opinion.

37. The major reason Weand has been hospitalized for the past five months is that the hospital's agents and employees have considered his attitude hostile and aggressive. The basis for this "hostile" and "aggressive" attitude is Weand's belief that he doesn't belong in the mental hospital and Weand's questioning and criticism of the hospital regimen and his treatment there.

*The Statutory Scheme*

38. Section 402 of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (50 P.S. § 4402) provides as follows: (Those parts which are challenged as unconstitutional by this Complaint are emphasized by underlining [italics])

Section 402. Voluntary Admission; Application, Examination and Acceptance; Duration of Admission.

(a) Application for voluntary admission to a facility for examination, treatment and care may be made by:

(1) Any person *over eighteen years of age.*

(2) *A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.*

(b) When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he may be admitted.

(c) *Except where application for admission has been made under the provisions of Section 402(a)(2) and the person admitted is still eighteen years of age or younger,* any person voluntarily admitted shall be free to withdraw at any time. *Where application has been made under the provisions of Section 402(a)(2), only the applicant or his successor shall be free to withdraw the admitted person so long as the admitted person is eighteen years of age or younger.*

(d) Omitted here.



39. Section 403 of the Act (50 P.S. § 4403) provides as follows: (Those parts which are challenged as unconstitutional by this Complaint are emphasized by underlining [italics])

Section 403. Voluntary Commitment; Application, Examination and Acceptance; Duration of Commitment.

(a) Application for voluntary commitment to a facility for examination, treatment and care may be made by:

(1) Any person *over eighteen years of age.*

(2) *A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.*

(b) The application shall be in writing, signed by the applicant in the presence of at least one witness. When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he shall be committed for a period not to exceed thirty days. Successive applications for continued voluntary commitment may be made for successive periods not to exceed thirty days each, so long as care or observation is necessary.

(c) No person voluntarily committed shall be detained for more than ten days after he has given written notice to the director of his intention or desire to leave the facility, *or after the applicant or his successor has given notice of intention or desire to remove the detained person.*

(d) Omitted here.

40. The only other provisions for civil commitment to a mental health facility provided by the Act are:

a. Section 404 which permitted commitment of persons upon application of third parties (including parents, guardians, individuals standing in loco parentis, etc.) upon application with certificates of two physicians. Because of its denial of Constitutional Due Process rights, this section has been declared unconstitutional. See Section 404 and *Dixon v. Attorney General of the Commonwealth of Pennsylvania*, 325 F. Supp. 966 (M.D. Pa. 1971).

b. Section 405 permits involuntary detention of persons, regardless of age, under emergency conditions for no longer than ten days.

c. Section 406 permits involuntary commitment of persons, regardless of age, upon petition to the state court of common pleas, and after hearing and examination. The respondent to such petition has the right to notice of the hearing, the right to counsel and the opportunity and right to present testimony and evidence in his or her behalf and to confront his or her accusers. The court may order outpatient or partial hospitalization instead of in-hospital commitment.

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## VIII.
## FIRST CAUSE OF ACTION

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For a First Cause of Action, Plaintiffs reallege Paragraphs 1 through 40 above, which are incorporated herein by reference, and further allege:



41. Voluntary patients over eighteen years of age enter facilities under the Act on their own application and volition under Section 402 or 403 and may leave and discharge themselves either at any time (Section 402) or upon proper written notice (Section 403). Plaintiffs and their class are denied such entrance and separation from the facility by the challenged portions of these sections of the Act.

42. The statute thus creates two classes of potential and actual "voluntary" admittees, distinguishable only on the basis of age. There is no adequate state justification for this arbitrary classification.

43. A person over eighteen years of age who does not wish to enter a facility may be placed there involuntarily only upon the order of a court pursuant to the procedures, including a petition, notice and hearing, mandated by Section 406 of the Act. A person under eighteen years of age who does not wish to enter a facility may be placed there involuntarily simply upon the application of a parent, guardian or individual standing in loco parentis; no notice or petition is required nor is any sort of hearing or court order provided for.

44. The statute thus creates two classes of potential and actual involuntary admittees and committees, distinguishable only on the basis of age. There is no adequate state justification for this arbitrary classification.

45. The challenged portions of the Act, and Defendants' actions in operating, enforcing and executing the same, deny Plaintiffs and their class the equal protection of the laws in violation of the Fourteenth Amendment to the United States Constitution.

## IX.
## SECOND CAUSE OF ACTION

For a Second Cause of Action, Plaintiffs reallege Paragraphs 1 through 40 above, which are incorporated herein by reference, and further allege:

46. By operation of the challenged portions of the Act, Plaintiffs and their class are detained and incarcerated involuntarily in mental hospitals and other facilities without:

a. the right to notice;

b. the right to a hearing;

c. the right to counsel and, if indigent, appointment of counsel;

d. the right to present evidence and testimony on their own behalf;

e. the right to subpoena witnesses and documents;

f. the right to confront and cross-examine witnesses against them and those who wish them to enter a facility;

g. the right to independent expert examination and assistance;

h. the right to be involuntarily detained only upon decision of a distinterested and impartial decision-maker;

i. the right to be involuntarily detained only upon a decision that they are in need of care treatment or observation, such decision being based on clear and convincing evidence;



j. the right to appeal and review, including provision for assistance of counsel and record and transcript without cost if appellant is unable to pay the cost thereof;

k. other procedural safeguards.

47. By operation of the challenged portions of the Act, and by Defendants' actions in operating, enforcing and executing the same, Plaintiffs and their class are deprived of their life, liberty and property without due process of law in violation of the Fourteenth Amendment to the United States Constitution.

## X.
## PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully pray, on behalf of themselves and all others similarly situated, that this Honorable Court:

1. Assume jurisdiction of this cause, convene a three-judge court pursuant to 28 U.S.C. §§ 2281 and 2284 to determine this controversy, and set this case promptly for an expedited hearing;

2. Determine by Order, pursuant to Rule 23(c)(1) of the Federal Rules of Civil Procedure, that this action be maintained as a class action;

3. Enter a final judgment, pursuant to 28 U.S.C. §§ 2201 and 2202 and Rule 57 of the Federal Rules of Civil Procedure declaring that the challenged portions of the Pennsylvania Mental Health and Mental Retardation Act of 1966, that is 50 P.S. §§ 4402(a)

(1), 4402(a)(2), 4402(c), 4403(a)(1), 4403(a)(2) and 4403(c) (see paragraphs 38 and 39 above), are invalid, void and of no effect on the grounds that they violate the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution;

4. Enter preliminary and permanent injunctions enjoining Defendants from enforcing and executing such statutory provisions;

5. Award damages to each of the named Plaintiffs in the amount of $15,000 each for unconstitutional deprivation of their rights;

6. Allow Plaintiffs their costs herein and reasonable attorney's fees;

7. Grant such additional and alternative relief as may be deemed by this Court appropriate, just, proper and equitable.

Respectfully submitted,

(s) David Ferleger
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On the Brief:
Ronald Soskin
Stan Abramson

Dated November 16, 1972



## MOTION TO DISMISS

---

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF
PENNSYLVANIA

---

Civil Action No. 72-2272

---

Kevin Bartley, et al.,
Plaintiffs

v.

Haverford State Hospital, et al.,
Defendants

---

## MOTION TO DISMISS

---

Defendants move that this Honorable Court dismiss the above captioned action on the basis that Plaintiffs have failed to plead an action upon which relief may be granted.

Marx S. Leopold
*Assistant Attorney General*

December 12, 1972

## ANSWER

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF
PENNSYLVANIA

Civil Action No. 72-2272

Kevin Bartley; Steve Gentile; Leslie Levine; Vicki Mathews; Mark Weand, minors, through their next friend, individually and on behalf of all others similarly situated,

Plaintiffs

v.

Jack B. Kremens, Hospital Director of Haverford State Hospital; Helene Wohlgemuth, Secretary of Public Welfare of the Commonwealth of Pennsylvania; William B. Beach, Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,

Defendants

## ANSWER

*First Defense*

*Preliminary Statement*

Plaintiffs in this Complaint attack the constitutionality of Sections 402 and 403 of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (50 P.S. 402, 403) which permits the voluntary commitment of persons 18 years of age or under by parents or persons standing in loco parentis. Defendants contend that these portions of the Act as well as regulations adopted in September, 1973, maintain the constitutionality of the attacked regulations and furthermore do not conflict with the Fourteenth Amendment to the United States Constitution.



*Second Defense*

Defendants admit the allegations contained in Paragraphs 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21, 24, 26, 29, 33, 41, 38, 39, and 40; admit in part allegation 22 that Plaintiff Bartley who was discharged on April 1, 1973, did not wish to enter the hospital nor remain and that Plaintiff Bartley was critical of hospital procedures and deny that any hospital procedures are arbitrary or inconsistent with beneficial treatment; admit in part allegation 23 that Defendants knew Plaintiff Bartley planned to go to school and learn a useable trade upon release because Defendants made arrangements for said school and deny that "nothing worthwhile is occurring to him inside the hospital" when in fact Plaintiff Bartley was receiving specialized treatment; admit in part allegation 28 that Plaintiff Levine's parents are divorced, that her father is remarried and living in Florida, that she would like to live with her father, and deny that she was solely committed to the hospital because she does not get along with her mother and sister when in fact she has threatened their lives several times and suffers from a personality disorder; admit in part allegation 32 that Vicki Mathew's parents on November 7, 1972 applied for and received Plaintiff Mathew's discharge from the hospital, that Defend-

ants are without knowledge or information sufficient to form a belief as to the truth of the allegations concerning Plaintiff's parents' financial means; admit in part in allegation 34 that Plaintiff Weand did not wish to become a mental patient and has informed Defendants' agents and employes of his desires to leave which occurred on December 1, 1972, that Defendants deny that Plaintiff Weand was admitted because of excess use of drugs when in fact that is part of his problem which is a psychiatric maladjustment; admit in part in allegation 35 that Plaintiff Weand has not been involved with any therapeutic drug program because his condition warrants other treatment programs in which he has participated; admit in part in allegation 43 that a person over 18 years of age who does not wish to enter a facility may be placed there involuntarily upon Order of the court pursuant to a petition, notice and hearing mandated by Section 406 of the Act, that Defendants deny that persons under 18 years of age who do not wish to enter a facility may be placed there when in fact adopted regulations of September, 1973 reveal that a juvenile who objects will be afforded counsel and ultimately a 406 hearing; and deny each and every other allegation contained in the Complaint.

Respectfully submitted,

BARRY A. ROTH
MARX S. LEOPOLD
*Assistant Attorneys General*
ISRAEL PACKEL
*Attorney General*
Counsel for Defendants

Dated: June 3, 1974



## CERTIFICATE OF SERVICE

I certify that on this day of June, 1974, I mailed true and correct copies of the foregoing to David Ferleger, Esquire, Counsel for Plaintiffs, at his office at the Mental Patient Civil Liberties Project, Suite 1407, 1315 Walnut Street, Philadelphia, Pennsylvania 19107.

BARRY A. ROTH
*Assistant Attorney General*

OPINION—JULY 24, 1975

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

Kevin Bartley, et al.

vs.

Jack B. Kremens, individually and as Hospital Director of Haverford State Hospital, et al.

Before Honorable John J. Gibbons, Circuit Judge, and Honorable Daniel H. Huyett, 3rd, and Honorable Raymond J. Broderick, District Judges

HUYETT, J., July 24, 1975:

## OPINION AND ORDER

Plaintiffs have filed this class action[1] on behalf of the named plaintiffs and all persons eighteen years of age or younger who have been, are, or may be admitted or committed to mental health facilities in Pennsylvania under the Pennsylvania Mental Health and Mental Retardation Act (Act). 50 P.S. §§4402 and 4403 (§§402 and 403).[2] Invoking 28 U.S.C. §1331 and 1343 (3) and 42 U.S.C.

[1] On April 29, 1974, we ordered that this action be maintained as a class action but left open the possibility that the definition of the class set out in the text might be amended or altered before the decision on the merits. We now find that this definition of the class is appropriate. We note that this action concerns children who allegedly are mentally ill as well as children who allegedly are mentally retarded.



[2] Section 402 of the Pennsylvania Mental Health and Mental Retardation Act of 1966 provides in part:

Section 402. Voluntary admission; application, examination and acceptance; duration of admission.

(a) Application for voluntary admission to a facility for examination, treatment and care may be made by:

(1) Any person over eighteen years of age.

(2) A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.

(b) When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he may be admitted.

(c) Except where application has been made under the provisions of Section 402(a)(2) and the person admitted is still eighteen years of age or younger, any person voluntarily admitted shall be free to withdraw at any time. Where application has been made under the provisions of Section 402 (a)(2), only the applicant or his successor shall be free to withdraw the admitted person so long as the admitted person is eighteen years of age or younger.

Section 403 of the Pennsylvania Mental Health and Mental Retardation Act of 1966 provides in part:

Section 403. Voluntary commitment; application, examination and acceptance; duration of commitment.

(a) Application for voluntary commitment to a facility for examination, treatment and care may be made by:

(1) Any person over eighteen years of age.

(2) A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.

§1983, plaintiffs ask us to declare §§402 and 403 unconstitutional and to enjoin their enforcement.[3]

Plaintiffs contend that in violation of the Fourteenth Amendment to the United States Constitution, they are being denied both due process of law and equal protection of law because Pennsylvania allows plaintiffs and their class to be detained—denied their liberty—in mental institutions without substantial procedural safeguards including the: (1) right to notice; (2) right to a pre-commitment hearing; (3) right to counsel and if indigent appointment of counsel; (4) right to present evidence on

(b) The application shall be in writing, signed by the applicant in the presence of at least one witness. When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he shall be committed for a period not to exceed thirty days. Successive applications for continued voluntary commitment may be made for successive periods not to exceed thirty days each, so long as care or observation is necessary.

(c) No person voluntarily committed shall be detained for more than ten days after he has given written notice to the director of his intention or desire to leave the facility, or after the applicant or his successor has given written notice of intention or desire to remove the detained person.

[3] Plaintiffs do not challenge either Section 405 or 406 of the Pennsylvania Mental Health and Mental Retardation Act of 1966. Section 405 permits involuntary detention of persons, regardless of age, under emergency conditions for no longer than 10 days. Section 406 permits involuntary commitment of persons upon petition to the state court of common pleas and after hearing and examination. The person to be committed is entitled to notice of hearing, the right to counsel, and the opportunity and right to present testimony and evidence in his or her behalf and to confront his or her accusers. The court may order outpatient or partial hospitalization instead of in-hospital commitment.



their own behalf; (5) right to subpoena witnesses and documents; (6) right to confront and cross-examine witnesses against them and those who wish to admit or commit them; (7) right to be involuntarily detained only upon a decision of a judicial officer; (8) right to be involuntarily detained only upon a decision that they are in need of treatment, care, or observation.[4] Plaintiffs also contend that the regulations supplementing §§402 and 403 do not cure these sections of their constitutional infirmities because they apply only to children 13 years of age or older, require no pre-commitment hearing, and designate no time by which a post-commitment hearing must be held.[5] In essence, plaintiffs claim that the present pro-

[4] We are not presented with the issue of what standards are needed for commitment. For an analysis of this question see the recent opinion of J. Hoffman in *Commonwealth ex rel. Charles Finkin, Jr. v. Roop,* Pa. Superior Ct. (1975). Also see, *Bell v. Wayne County,* 384 F. Supp. 1085, 1095 (E.D. Mich. 1974).

[5] After plaintiffs filed this action the Department of Public Welfare, pursuant to Section 201(2) of the Pennsylvania Mental Health and Mental Retardation Act of 1966, adopted additional procedural safe-guards for children admitted or committed to institutions pursuant to Sections 402 and 403. These regulations provide in part:

1. All juveniles aged 18 and younger to be admitted to an Institution must be referred from a recognized medical facility Mental Health/Mental Retardation therapist or Mental Health Agency; however, mentally retarded juveniles may be referred by either a pediatrician, or general physician or psychologist;

2. This referral must be accomplished by a psychiatric evaluation and that report must indicate with specificity the reasons that the person requires institutional care; however, a medical or psychological evaluation may accompany the referral of a mentally retarded juvenile;

cedures do not adequately assure against the mistaken commitment of children who are not mentally ill.

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3. The Director of the Institution or his delegate, shall have conducted an independent examination of the proposed juvenile, and if his results disagree with the professional's opinion, the Director, or his delegate shall discharge the juvenile;

4. The telephone number and address of the juvenile's parents or the person who is requesting admission for the juvenile must accompany the referral;

5. Within 24 hours after the juvenile's admission, every youth who is at least 13 years of age must receive written notification (which he signs) explaining his rights indicating that he will be given a status report periodically of his condition; that he can contact by telephone or by mail his parents or the person who requested his admission; and that he will be furnished with the number of counsel (Public Defender's number; Legal Services) that he can call for representation. An appropriate person shall explain this notice (attached);

6. In the event that a juvenile whose chronological age is 13 or older objects (either orally or in writing) to remaining in the Institution, the Director, or his delegate, if he feels it is necessary for the youth to remain, may continue the institutionalization for two business days during which time he shall notify the applicant and the referral unit so that either party may institute a 406 proceeding. During that same two-day period, the Director, or his delegate, shall notify the Public Defender's Office or notify Legal Services readily available of the juvenile's need for legal representation. If a 406 proceeding is begun during the two-day period, the juvenile shall remain institutionalized. If the applicant cannot be located and the Director, or his delegate, feels that the juvenile does not require institutionalization, the Director, or his delegate, shall direct the Base Service Unit to assume responsibility of providing for the juvenile's aftercare. However, if the Director, or his delegate, feels that the juvenile requires institutionalization, he shall direct the Base Service



In support of their claim that §§402 and 403 are unconstitutional, plaintiffs have submitted brief summaries of the reasons for the commitment of the named plaintiffs and other members of their class to demonstrate that many decisions to commit involve factual determinations requiring substantial procedures to guard against wrongful or erroneous commitment. We rely for our findings on the summaries contained in the final pretrial order which have been stipulated to and on defendants' exhibit numbered eight (8).

The named plaintiffs were either admitted under §402 or committed under §403 to Haverford State Hospital.[6] Plaintiff M.W. was admitted to Haverford State

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Unit to file a 406 proceeding within two days after failure to locate the applicant;

7. The juvenile's counsel shall be furnished with the juvenile's evaluation from the referral unit, with a psychiatric evaluation from the Institution, and with a written report of the reasons to institutionalize the juvenile;

8. If the staff member of the facility giving notice to the patient determines that the patient is incapable of understanding the notification, it shall be written on the notification;

The regulations do not provide a time by which a commitment hearing must be held. The Attorney General of Pennsylvania assures us that in cases involving children at least 13 years of age, commitment hearings are scheduled within a short while after the child objects. With respect to children 12 years of age or younger, there is no requirement for a hearing, no less a designated time. Defendants submit that these regulations were not adopted with and towards this litigation and that with or without them, Sections 402 and 403 are constitutional.

[6] By stipulation Haverford State Hospital was withdrawn as a defendant. Haverford is a mental health "facility" under Section 102 P.S. §4102 of the Mental Health and Mental Retardation

Hospital under §402(a)(2). His mother admitted him allegedly against his wishes when he was fifteen and on December 1, 1972, he informed agents and employees of defendant of his desire to leave Haverford State Hospital. Plaintiffs K.B., S.G., L.L., and V.M. were committed to Haverford State Hospital under §403(a)(2). Plaintiff K.B. was fifteen when his mother committed him against his wishes. He was and still is critical of some of the hospital's regulations and treatment practices. Plaintiff S.G. was seventeen when his father committed him allegedly against his wishes. Plaintiff L.L. was fifteen when her mother committed her allegedly against her wishes. Her difficulties in relating to her mother resulted in her commitment. Hospital records show that she threatened the lives of her mother and sister and that she has a personality disorder. Her parents are divorced and her father is remarried, living in Florida. At the time of her commitment and the time this action was filed, she would have preferred to have been with her father and when she is with him her behavior is excellent. Plaintiff V.M. was fourteen when her mother committed her allegedly against her wishes.

Members of plaintiffs' class have been institutionalized for various other reasons. Patient number 13,173, a moderately retarded 13 year old child, was institutionalized in Polk State Hospital because of very sudden, explosive, rage reactions during which he attacked others and of which he has no recollection. His behavior rather than his mental retardation was the primary obstacle to his return to the community. Patient number 13,212, an

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Act. It receives admissions and commitments of persons including persons eighteen years of age or younger admitted or committed under Sections 402 and 403.



educable mongoloid boy with the capacity to participate in many educable and trainable activities and who can be helped by an active special elementary program in public schools, was institutionalized in Polk State Hospital for a 1 to 2 week period so that the other members of his family could go on a family vacation. Patient number 288, a mentally retarded child, was placed in Western State Hospital because of a poor family situation. The mother of the child did not get along well with the child, and the family was afraid that she would have another nervous breakdown if the child were not placed in Western State Hospital. Patient number 281, a mentally retarded child, was placed in a state institution because she had become a management problem to both her parents and the community. Patient number 15, a mentally retarded child, was placed in Western State Hospital because the child interfered with the routine of the household and disturbed family members. The placement was based on a fear that if the child remained in his home, the mother might break down, the marriage of the child's parents might end in separation, the father's health might fail, and an adolescent daughter might be pushed into a premature marriage to escape an unhappy home. Class members have also been committed to mental hospitals for running away, robbing a gas station, stealing in general, chasing and striking a girl, arson, delinquent behavior in general, truancy, physical ailments such as colitis and weight loss, school phobia, and drug overdose.

At the time this action was filed defendants were all Pennsylvania officials with specific duties under the Act. Defendant Jack B. Kremens as Hospital Director of Haverford State Hospital was charged under 50 P.S. §§4102 and 4203 with supervision and administration of Haver-

ford State Hospital. It was to Kremens or his delegates that application for admission and commitment under §§402 (b) and 403 (b) of the Act had to be made. Defendant Helene Wohlgemuth as Secretary of Public Welfare of the Commonwealth of Pennsylvania (Secretary) had the power under 50 P.S. §§4201 and 4202 (a) to enforce the Act, to make all regulations necessary and appropriate to the proper accomplishment of the Act, and to operate and assign functions to all state facilities. Defendant William B. Beach as the Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania had the general authority to supervise and regulate mental health facilities in Pennsylvania.

At the outset, defendants contend that since the purpose of the Act is to meet the child's needs through treatment and rehabilitation rather than to punish the child by incarceration for what he has done, the requirements of due process do not apply to the institutionalizing of children under §§402 and 403.[7] Defendants proceed to argue

[7] A number of defendants in similar cases have raised this argument. In *In re Gault*, 387 U.S. 1, 21 (1966), defendants claimed that juveniles obtain benefits from the informal juvenile procedures which more than offset the disadvantages of denying them the substance of normal due process. The Court rejected this argument holding:

> observance of due process standards, intelligently and not ruthlessly administered, will not compel the States to abandon or displace any of the substantive benefits of the juvenile process.

In *Denton v. Commonwealth*, 383 S.W. 2d 681 (Ky. 1964), cited approvingly by Judge Biggs in *Dixon v. Attorney General of Pennsylvania*, 325 F. Supp. 966, 972 (M.D. Pa. 1971), the court also rejected this argument holding that commitment procedures should be the same in civil commitment proceedings as they are in criminal proceedings. Responding to this same argument, Judge Biggs in *Dixon* stated: "We are unimpressed by the parens patriae argument and strong courts have not been persuaded by it." (citations omitted). In Holm v. State, 404 P. 2d 740, 742 (Wyo. 1965) the Wyoming Supreme Court held:

> No matter how commendable the motives back of legislation for the mentally ill may be it still remains the fundamental law of the land that a person is not to be deprived of his liberty—whether by involuntary hospitalization or some other kind of incarceration—without due process of law.

In *Heryford v. Parker*, 396 F.2d 393 (10 Cir. 1968), the court held that even if the institutionalizing of children is for rehabilitation, the constitutional safeguards of due process must be observed. The court in *Lessard v. Schmidt*, 349 F. Supp. 1078 (— Wis. 1972), was faced with the argument that due process procedures should be relaxed because of a subsequent right to treatment and because the commitment proceedings were civil in nature. After examining the effect civil commitment may have on those adjudged mentally ill, the court rejected these arguments and held that all persons 18 years of age or older being held pursuant to any emergency, temporary, or permanent commitment provision of the Wisconsin involuntary commitment statute, were entitled to substantial procedural safeguards. *Saville v. Treadway*, F. Supp. (M.D. Tenn. 1974) presented a challenge to a Tennessee Statute which permitted the "voluntary" commitment of juveniles by a parent, guardian, or person having legal custody of a mentally retarded minor. While recognizing the services furnished to mentally retarded children by the state, and the efforts in mental rehabilitation of the state, the court held that "where individual liberty is at stake . . . it is absolutely essential that such confinement be preceded by adequate procedural safeguards."



that if we determine that due process applies, we should find that in light of Pennsylvania's interest in protecting the child, preserving the family unit, maintaining the rights of parents to the custody, care, and upbringing of their children, and protecting society, the present statutes and

regulations satisfy any due process requirements. Finally, defendants argue that since under §§402 and 403 the parents, guardians ad litem, or persons standing in loco parentis must set into motion the commitment machinery, these persons effectively waive any due process rights of plaintiffs and their class.

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## DISCUSSION

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Under the constitutional guarantee of procedural due process, we have developed a system whereby a person who may be subjected to a grievous loss of liberty is entitled to adequate procedural safeguards. *Wolff v. Mc Donnell,* 418 U.S. 539 (1974). Generally, the state is required to provide substantial procedures when there is the possibility of erroneously and wrongfully depriving persons of their liberty by committing them to mental institutions. See, concurring Opinion of Chief Justice Burger in *O'Connor v. Donaldson,* 43 U.S.L.W. 4929, 4935 (1975); *Lynch v. Baxley,* 386 F. Supp. 378 (M.D. Ala. 1974); *Lessard v. Schmidt,* 349 F. Supp. 1078, remanded 414 U.S. 473 (1974), redecided 379 F. Supp. 1376 (1974), remanded 43 U.S.L.W. 3600 (May 12, 1975); *Dixon v. Attorney General Commonwealth of Pennsylvania,* 325 F. Supp. 966 (M.D. Pa. 1971). These safeguards attempt to protect persons from an arbitrary or erroneous deprivation of liberty or property, whether that deprivation be imposed for benevolent or punitive reasons. They are "our best instruments for the distillation and evaluation of essential facts from the conflicting welter of data that life and our adversary methods present." They "enhance the possibility that truth will emerge from the confrontations of opposing versions and



conflicting data." *In re Gault,* 387 U.S. 1, 21 (1966). As Mr. Justice Frankfurter has said: "The history of American freedom is, in no small measure, the history of procedure." *Malinski v. New York,* 324 U.S. 401, 414 (1945) (separate opinion) cited by the majority in *In re Gault,* at 21. If we are to preserve our traditional liberty we must scrutinize with care any claim that it is being arbitrarily denied.

In deciding whether the requirements of due process apply in any given case, the threshold question is whether the interest of the complaining party is within the contemplation of the liberty or property language of the Fourteenth Amendment. *Morrissey v. Brewer,* 408 U.S. 471, 481 (1971). The particular question here is whether or not a child's interest in not being institutionalized under §§402 and 403 is safeguarded by the Fourteenth Amendment. Defendants would have us find that because Pennsylvania is acting as parens patriae and not as an adversary, and because the admission and commitment proceedings are civil, not criminal, in nature, plaintiffs and their class may not complain of the deprivation of procedures available in criminal cases. Such a finding would ignore that the child is involuntarily removed from his home and familiar surroundings and is committed to an institution where "[he] suddenly faces the regimented routine of ward life and daily confrontation with state employees, however capable, rather than family and friends." *In re Ballay,* 482 F.2d 648, 669 (D.C. Cir. 1973). As the Court of Appeals for the Tenth Circuit noted in *Heryford v. Parker,* 396 F.2d 393, 396 (1968):

> It matters not whether the proceedings be labeled "civil" or "criminal" or whether the subject matter be mental instability or juvenile delinquency. It is

> the likelihood of involuntary incarceration whether for punishment as an adult for a crime, rehabilitation as a juvenile for delinquency, or treatment and training as a feeble-minded or mental incompetent—which commands observance of the constitutional safeguards of due process.

Defendants' contention also ignores the stigma associated with civil commitment which some commentators and courts have noted may render civil commitment a more lasting abridgement of personal freedom than imprisonment for commission of a crime.[8] The child who faces

[8] Loss of liberty is in issue not only when a person is physically confined. The Due Process Clause also affords protection "where a person's good name, reputation, honor, or integrity is at stake because of what the government is doing to him." *Wisconsin v. Constantineau*, 400 U.S. 433, 437 (1971); *Board of Regents v. Roth*, 408 U.S. 564, 573 (1972); *Goss v. Lopez*, 419 U.S. 565 (1975); *Donalds v. O'Connor*, 493 F.2d 507, 520 (5 Cir. 1974), vacated and remanded *O'Connor v. Donaldson*, 43 U.S.L.W. 4929 (1975).

While we hope that society is moving in the direction of viewing mental illness in the same light as physical illness, we cannot ignore the reality that many in our society view mental illness with disdain or apprehension. See *In re Ballay*, 482 F.2d 648, 668 (D.C. Cir. 1973), where the court noted that, "[e]ven accepting recent medical advances, current studies clearly indicate the fallacy of contending that most people view mental illness as a disease similar to any physical ailment of the body" and that it could not "ignore the striking example of this attitude displayed by news stories and public reaction to disclosures made by a recent vice-presidential aspirant." In *Pennsylvania Association for Retarded Children v. Commonwealth of Pennsylvania*, 343 F. Supp. 279, 293 (E.D. Pa. 1972), Judge Masterson, writing for the three judge court, held that in light of *Wisconsin v. Constantineau, supra*, due process requires a hearing before retarded children may be denied a public education because of the stigma which our society unfortunately attaches to the label of mental retardation.



the possibility of being physically confined for an indeterminate period with all of the ramifications of such confinement clearly has an interest within the contemplation of the liberty and property language of the Fourteenth Amendment.

Having decided that due process applies, we are left with the questions of what process is due, *Morrissey v. Brewer, supra,* at 481 and whether this process may effectively be waived by plaintiffs' parents, guardians ad litem, or persons standing in loco parentis.[9] Before discussing the process here, we shall first consider whether or not parents, guardians ad litem, or persons standing in loco parentis may effectively waive the personal rights of children, since such a finding obviates the need to decide whether the present procedure violates the constitutional right of plaintiffs to procedural due process. The question is both difficult and unique. Viewing the issue as whether or not a parent may effectively waive personal rights of a child when the child objects to the waiver creates a confrontation between a liberty interest of plaintiffs we find constitutionally protected and the consistently recognized authority of parents to direct the rearing of their children. *Ginsberg v. New York*, 390 U.S. 629, 639 (1968).

We presume that in most instances parents, proceeding in utmost good faith, acting for the child, in the child's

[9] As yet, the Supreme Court has not decided whether the child's parent, acting on behalf of the child, may effectively waive constitutional rights of the child. In *Heryford v. Parker, supra,* the court, in holding that the Due Process Clause applies to an involuntary civil commitment procedure, recognized that special problems may arise with respect to the effective waiver of rights by minors and mentally deficient persons. Finding that there was no express attempt to make such a waiver, the court did not decide the issue.

best interests, properly guide, protect, and control their children. In *Wisconsin v. Yoder*, 406 U.S. 205, 231, 232 (1971), the Supreme Court, stating that it was not determining the proper reconciliation of possible competing interests of parents, children, and the state, noted that:

> The history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children. This primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition.

Also see, Justice Stewart's concurring opinion at 237. We are not unmindful of this tradition and its importance to the structure of our society, *Ginsberg* at 639, and if we could find that in all instances parents act in the best interest of their children, we might also find that parents may waive constitutional rights of their children. Unfortunately, as such a graphic example as parental child abuse illustrated,[10] this is not the case.[11] In deciding to institutionalize their children, parents, as well as guardians

[10] See Memorandum and Order of Judge Urbom filed June 4, 1974, in *Horacek, etc., v. Exon, et al.*, Civil Action No. 72-L-299 (D.C. Neb. 1974). The claim before Judge Urbom was that the named plaintiffs were in a state hospital because their parents put them there. Responding to the argument that plaintiffs were in the hospital voluntarily because their parents placed them there, Judge Urbom held that "parents cannot deprive their children of constitutional rights—rights of the children vis-a-vis the state."

[11] Dissenting in *Kent v. United States*, 401 F.2d 408, 416, n.4 (D.C. Cir. 1968), the now Chief Justice Burger noted:

> Lawmakers in recent years have been sensitive to the need to make civil commitment difficult recognizing the dangers of relatives "farming" out their kindred into mental institutions for motives not always worthy.



ad litem or persons standing in loco parentis, may at times be acting against the interests of their children. With this in mind we must agree with Judge Judd in *New York State Association for Retarded Children*, 357 F. Supp. 752, 762 (E.D.N.Y. 1973), that, "in the absence of evidence that the child's interests have been fully considered," parents may not effectively waive personal constitutional rights of their children.[12]

Remaining is the question of what process is due. Due process is flexible in that a determination of what process is due cannot be made without an evaluation of "the precise nature of the government function involved as well as of the private interest that has been affected by government action." *Cafeteria Workers Union v. McElroy*, 367 U.S. 886, 895 (1961). At a minimum, it requires that "deprivation of . . . liberty . . . by adjudication be preceded by notice and opportunity for hearing appropriate to the nature of the case,"[13] but the formalities of

In *New York State Association for Retarded Children, Inc. v. Rockefeller*, 357 F. Supp. 752, 762 (E.D.N.Y. 1973), the court stated:

> [t]here may be a fundamental conflict of interest between a parent who is ready to avoid the responsibility of caring for an abnormal child, and the best interests of the child. Murdock, [Civil Rights of the Mentally Retarded: Some Critical Issues], 48 Notre Dame Lawyer at 139-143.

[12] This finding does not mean that when considering whether or not to institutionalize a child, the state should ignore the opinions and observations of the child's parents. Rather, the committing authorities should listen carefully to parents who live with and observe the child on a daily basis for they very likely have invaluable information concerning their child.

[13] *Goss v. Lopez*, 419 U.S. 565, 79 (1975), citing *Mullane v. Central Hanover Trust Co.*, 339 U.S. 306, 313 (1950).

the procedure however, "the timing and content of the notice and the nature of the hearing will depend on appropriate accommodation of the competing interests involved."[14] Because courts cannot determine what process is due without evaluating the competing interests, the content of due process shifts as the interests shift; "[t]he required degree of procedural safeguards varies directly with the importance of the private interest affected and the need for and usefulness of the particular safeguard in the given circumstances and inversely with the burden and any other adverse consequences of affording it."[15]

As previously discussed, plaintiffs' interest in being free from the wrongful and unwarranted deprivation of their liberty is substantial and they argue that the present procedure does not adequately protect this interest. The state's interests are threefold. It has an interest in the mental health of children (parens patriae), an interest in preserving the family unit and maintaining parental authority over children, and an interest in confining, for the protection of society those persons who pose significant danger to the community (police power). The state has decided that its interests require a relaxed, informal procedure, and it argues that a more formal procedure will substantially interfere with its interests. To strike a proper balance between the competing interests of plaintiffs and the state, we shall analyze them in the context of each procedural right of which plaintiffs claim they are being deprived. This will give us the content of the process

[14] *Goss v. Lopez*, at 579, citing *Cafeteria Workers v. McElroy*, 367 U.S. 886, 895 (1961); *Morrissey v. Brewer, supra*, at 481.

[15] See, Friendly, J. "Some Kind of Hearing", 123 U. Pa. L. Rev. 1267, 1278 (1975).



which, at a minimum, is due before plaintiffs may be institutionalized for treatment.[16]

## PRE-COMMITMENT HEARING

A decision to institutionalize a child is often a difficult yet necessary decision for a child's parent to make. It is generally pursued only after all other alternatives have proven futile. The state has an interest in seeing that a procedural system will not deter parents, already faced with this difficult decision, from attempting to institutionalize children who are in need of treatment only mental institutions can provide. Further, to protect society and the individual child, the state has an interest in the immediate detention of children who may be dangerous to themselves or others. See, *Lessard v. Schmidt*, at 1092; Developments in the Law—Civil Commitment of the Mentally Ill, 87 Harv. L. Rev. 1190, 1275 (1974).

[16] As we have already noted, due process is flexible; the Constitution mandates no specific code of procedures. We are aware of the problems facing courts when they attempt to fashion procedures protecting interests within the liberty and property language of the FourteenthAmendment and we are sensitive to the claim that courts are "good at deciding cases, bad at drafting legislation. . . ." See, Friendly, J. "Some Kind of Hearing" supra. When presented with claims of constitutional dimension, however, we are constrained, when legislative bodies have failed to act, to find means of enforcing the constitutional rights being denied. Our action is not intended to pre-empt the state which is free to develop its own safeguards so long as they are as fully effective as those which we set out. See *Miranda v. Arizona*, 384 U.S. 436, 490 (1966); *Morrissey*, at 490.

Balancing these substantial interests of the state with that of the child, we find that plaintiffs are not entitled to a pre-commitment hearing. As the Supreme Court has found with criminal cases, however, we find that, for the protection of the child, he is entitled to a hearing before an unbiased tribunal within a reasonable time to test whether there is probable cause to believe institutionalization is necessary. *McNabb v. United States,* 318 U.S. 332, 343-344 (1943); *Morrissey v. Brewer,* at 489 (1971); *Lynch v. Baxley,* at 388. In no event shall detention of the child in the absence of a probable cause hearing exceed seventy-two (72) hours from the date of the initial detention. See, *Lynch v. Baxley,* at 388; *Lessard v. Schmidt,* at 1091.[17]

## POST-COMMITMENT HEARING

If the conclusion of the preliminary hearing is that there is probable cause for believing the child needs institutionalization, the child is entitled to a post-commitment hearing before an unbiased tribunal on the need for commitment. A delay after the probable cause hearing is permissible. This delay will allow the child to adjust to his new surroundings and will allow both the state and the child time to prepare for the post-commitment hearing to come. It will also allow the state time to examine and

[17] In *Lynch v. Baxley,* at 388, the court held that emergency detention without a hearing on its appropriateness may not, in the absence of a probable cause hearing, exceed seven (7) days from the date of the initial detention. In *Lessard v. Schmidt,* at 1091, the court held that a probable cause hearing must be held within forty-eight (48) hours from the date of the initial detention.



diagnose the child adequately. These reasons do not, however, justify a prolonged period of confinement without a final determination on the need for institutionalization and should not exceed a two-week period. A two-week period will afford all parties an opportunity to prepare adequately and properly their positions with hope of ascertaining that which is best for the child.[18]

## NOTICE

The opportunity to be heard is fundamental to due process of law. *Grannis v. Ordean,* 234 U.S. 385, 394 (1914). Without notice of that which is to transpire at a hearing "sufficiently in advance of any required hearings so that reasonable opportunities to prepare will be afforded," *In re Gault,* at 33; *Lessard v. Schmidt,* at 1092; *Lynch v. Baxley,* at 388, the right to be heard has little significance. *Mullane v. Central Hanover Tr. Co.,* at 314. To counterbalance this substantial interest of plaintiffs the state argues that by delaying treatment and traumatizing the child, the requirement of notice will aggravate the child's mental illness, interfere with the state's police power, and disrupt family harmony. In *Gault* at 21, the Supreme Court refused to accept the state's fear of trauma as a justification for limited procedures. The Court stated that the observance of due process standards will not necessarily compel the states to abandon the substantive benefits of the juvenile process. Further, as Judge Tamm

[18] Until the legislature acts to establish an unbiased tribunal to conduct the probable cause and final hearings the present facilities of the Commonwealth court system shall be used for these hearings.

noted in *In re Ballay*, 482 F.2d 648, 664 (D.C. Cir. 1973), the fear that added procedural requirements will produce trauma presupposes that the person who faces commitment is mentally ill. Likewise, while procedural safeguards assume that not all persons who face commitment need actually be committed, the argument that procedures will interfere with the state's police power and disrupt family harmony assumes that the child is dangerous to others and comes from a family in harmony.

Keeping in mind that due process assures against error, we find written notice required, including the date, time, and place of the hearing, and a statement of the grounds for the proposed commitment. See, *Lynch v. Baxley*, at 388; *Lessard v. Schmidt*, at 1092. Neither the state nor plaintiffs have an interest in committing to mental institutions children not in need of institutionalization. Notice should not shield children in need of institutionalization from commitment and treatment but rather should protect children not in need of institutionalization from wrongful commitment and improper deprivation of their liberty.[19]

## COUNSEL

The state fears that assistance of counsel will make institutionalization proceedings adversarial adding to the

[19] Obviously this notice may be meaningless to some children. We, therefore, find that until some other procedure is established this notice shall be sent not only to the child but also to the Clerk of the Court with jurisdiction and shall be forwarded to the child's attorney. The child's attorney shall be in receipt of the notice at least forty-eight (48) hours prior to the initial hearing.



delay in treatment of the child and increasing the danger of trauma already inflicted by notice and a hearing. Yet the spectre of this particular trauma pales beside the spectre of the trauma inflicted on a child erroneously committed.[20] Notice and the opportunity to be heard may be of little value without the assistance of counsel. *Argesinger v. Hamlin*, 407 U.S. 25, 31 (1972); *Powell v. Alabama*, 287 U.S. 45, 68-69 (1932). A child whose liberty is in question "needs the assistance of counsel to cope with problems of law, to make skilled inquiry into the facts, to insist upon regularity of the proceedings, and to ascertain whether he has a defense and to prepare and submit it." *Gault*, at 36. As the right to counsel applies to criminal cases, so it must apply during all significant stages of the commitment process, and plaintiffs must be informed of both their right to counsel and if indigent their right to appointment of free counsel. See, *In re Gault*, at 41; *Heryford v. Parker*, at 397; *Dixon v. Attor-*

[20] The possibility and danger of error is discussed by D. L. Rosenhan in "On Being Sane in Insane Places," 179 Science 250 (1973). The article describes an experiment in which eight sane persons gained admission to twelve different hospitals and behaved normally. Their sanity was never discovered. Not only was their sanity not detected, but the psychodiagnostic label placed on the individual patients was never removed. According to Professor Rosenhan this error apparently resulted from what statisticians call type two error—error resulting from a Doctor's inclination to call a healthy person sick rather than a sick person healthy because it is more dangerous to misdiagnose illness than health.

Rosenhan suggests that the initial labelings color others' perception of the patient and eventually the patient himself accepts the diagnosis, with all of its connotations and expectations, and behaves accordingly. He also notes that there is substantial evidence that attitudes towards the mentally ill are characterized by fear, hostility, aloofness, and dread.

*ney General,* at 966; *Lessard v. Schmidt,* at 1097; *Lynch v. Baxley,* at 389; *United States v. Wade,* 388 U.S. 218, 226-27 (1967); *In re Barnard,* 455 F.2d 1370, 1375-76 (D.C. Cir. 1971); *Sarzan v. Gaughan,* 489 F.2d 1076, 1083-84 (1 Cir. 1973).

## PRESENCE OF PERSON

In *Specht v. United States,* 386 U.S. 605, 610 (1967), the Supreme Court held that commitment proceedings under the Colorado Sex Offenders Act, whether denominated civil or criminal, are subject to the Due Process Clause of the Fourteenth Amendment and that due process requires that the person to be committed "be present with counsel, have an opportunity to be heard, be confronted with witnesses against him, have the right to cross-examine, and to offer evidence of his own." Also see, *Lynch v. Baxley,* at 394. In *Illinois v. Allen,* 397 U.S. 337, 342 (1969) the Court, rejecting the argument that the right to be present is absolute, held that the right of personally confronting witnesses may be lost by consent or at times even misconduct. Expanding this holding the *Lynch v. Baxley* court held that the right to be present may be knowingly and intelligently waived by persons faced with involuntary commitment or by adversary counsel acting in their behalf. This procedure protects such persons' constitutional right to be present and to assist in protecting their interests, yet it recognizes that situations exist where the absence of such persons from commitment proceedings may serve their own best interests.

We adopt the *Lynch v. Baxley* procedure as appropriate for plaintiffs. Accordingly, we find that a child



has a constitutional right to be present at all hearings concerning his proposed commitment. See, *McKiever v. Pennsylvania*, 403 U.S. 528, 543 (1971). This right may be waived by the child, however, and the unbiased tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them. This right may also be waived by the child's attorney, and the unbiased tribunal may accept the waiver upon a finding that the child is too ill to attend the proceedings. See, *Lynch v. Baxley,* at 394.

## RIGHT TO JURY TRIAL

The Supreme Court in *McKiever v. Pennsylvania, supra,* noting that conscientious judges are able fact finders, held that while fundamental fairness requires notice, the rights to counsel, confrontation, and cross-examination, and notice of standard of proof, it does not require jury trials. We agree.

## STANDARD OF PROOF

That the fact finder may commit error is a risk of any litigation. *Speiser v. Randall,* 357 U.S. 513, 525-26 (1958). The standard of proof affects this risk for it instructs the fact finder on the degree of confidence society expects him to have in the correctness of his findings. See Mr. Justice Harlan concurring in *In re Winship,* 397 U.S. 358, 370-71 (1969). In *Winship,* Justice Harlan suggests that setting the standard of proof for a particular category of adjudication reflects an assessment of the com-

parative social costs of erroneous factual determinations. He views the decision to apply a preponderance standard to suits between private parties for money damages as a decision that an erroneous verdict is no more serious for one party than for the other. He finds the standard of proof beyond a reasonable doubt required in the institutionalization of a child for delinquency because the social disutility of committing an innocent child—subjecting him to a complete loss of his personal liberty—outweighs the social disutility of committing error in his favor.[21]

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[21] Mr. Justice Harlan recognizes that in a judicial proceeding in which there is a dispute about the facts, all the fact finder can acquire is a belief of what probably happened. Mr. Justice White in *Goss v. Lopez*, 419 U.S. 565, 580 (1975) also recognized the possibilities of error when he noted that:

> Disciplinarians, although proceeding in utmost good faith, frequently act on the reports and advice of others; and the controlling facts and the nature of the conduct under challenge are often disputed. The risk of error is not at all trivial, and it should be guarded against if that may be done without prohibitive cost or interference with the educational process.

In discussing the possibilities of erroneous psychiatric diagnoses Rosenhan, in "On Being Sane in Insane Places," *supra*, raises several poignant questions which illustrate some of the problems in this area including:

> How many people, one wonders, are sane but not recognized as such in our psychiatric institutions? How many have been needlessly stripped of their privileges of citizenship, from the right to vote and drive to that of handling their own accounts? How many have feigned insanity in order to avoid the criminal consequences of their behavior, and, conversely, how many would rather stand trial than live indeterminably in a psychiatric hospital—but are wrongly thought to be mentally ill? How many have been stigmatized by well-intentioned but nevertheless erroneous diagnoses? On the last point recall again that a "type 2 error" in psychiatric diagnosis does not have the same consequences it does in medical diagnosis. A diagnosis of cancer that has been found to be in error is cause for celebration. But psychiatric diagnoses are rarely found to be in error. The label sticks, a mark of inadequacy forever.

These problems are similar to the problems discussed by Mr. Justice Harlan in *Winship* and Mr. Justice White in *Goss v. Lopez*.



Following this analysis, balancing the impact of an erroneous decision to commit a person with an erroneous decision to release a person, and taking into consideration the nature of the proceedings, the *Lynch v. Baxley* court held:

> Because the stigmatization and loss of liberty attendant upon forced confinement are of the most profound consequence to the individual affected, due process demands that he be subjected to such disabilities only if the necessity for his commitment is proved by evidence having the highest degree of certitude reasonably attainable in view of the nature of the matter at issue. In a civil commitment proceeding, the questions involved are the primarily subjective ones of the subject's mental condition and the likelihood that he will be dangerous in the future. Such subjective determinations cannot ordinarily be made with the same degree of certainty that might be achieved where purely objective facts and occurrences are at issue. Consequently, the trier of fact must be persuaded by clear, unequivocal, and convincing evidence that the subject of the hearing is in need of confinement under the minimum standards for commitment herein enumerated.

We agree with this holding and find that the fact finder, in a hearing on commitment of a child, must apply the standard of clear and convincing proof as opposed to the

standards of beyond a reasonable doubt and preponderance of the evidence. Applying a preponderance standard creates too great a risk of erroneous commitment, wrongfully depriving a child of his interest in liberty, and interest of "transcending value,"[22] and, given the subjectivity and "relatively undeveloped state of psychiatry as a predictive science,"[23] requiring proof beyond a reasonable doubt creates too great a risk of erroneously releasing children in need of institutionalization.

## RIGHTS AT THE COMMITMENT HEARING

Due process requires that before a decision to commit, an adult be given the opportunity to confront and to cross-examine witnesses against him, *Specht v. Patterson,* 386 U.S. at 610; *Lynch v. Baxley* at 394, offer evidence in his own behalf, *Specht v. Patterson* at 610, and offer testimony of witnesses, *Lynch v. Baxley* at 394, citing *White v. Texas,* 388 U.S. 14, 19 (1967).[24] While formalizing

[22] *Speiser v. Randall,* 357 U.S. 513, 525 (1958).

[23] Note, Developments in the Law, Civil Commitment of the Mentally Ill, 87 Harv. L. Rev. 1190, 1302 (1974).

[24] In *Morrissey v. Brewer, supra,* the Supreme Court held that due process requires certain minimum procedures before parole can finally be revoked. These procedures include the opportunity to be heard in person and to present witnesses and documentary evidence, and the right to confront and cross-examine adverse witnesses (unless the hearing officer specifically finds good cause for not allowing confrontation). Noting that these procedures are essential in criminal trials, where a person may be subjected to the most serious deprivation, and cases where a person may lose his job in society, the Supreme Court in *Wolff, supra,* held that because of the unique problems of penal institutions the determination of whether prisoners are entitled to these rights is best left to the discretion of the officials of the prisons.



commitment procedures, these rights do not require the state to abandon the substantive benefits it presently hopes to achieve through treatment and rehabilitation. We commend the steps the state has taken in the interest of the mental health of children in need of institutionalization but, because of the tremendous personal as well as societal loss error might cause, we find that in addition to the rights previously discussed, the rights to confront and to cross-examine witnesses against him, to offer evidence in his own behalf and to offer testimony of witnesses are required before a decision to commit a child is made.[25]

To summarize, then, we have found that before they may be institutionalized plaintiffs and others of their class are entitled to (1) a probable cause hearing within seventy-two (72) hours from the date of their initial detention; (2) a post-commitment hearing within two (2) weeks from the date of their initial detention; (3) written notice, including the date, time, and place of the hearing, and a statement of the grounds for the proposed commitment; (4) counsel at all significant stages of the commitment process and if indigent the right to appointment of free counsel; (5) be present at all hearings concerning their proposed commitment; (6) a finding by clear and convincing proof that they are in need of institutionaliza-

[25] In support of their position plaintiffs submitted memoranda of law outlining the substantial procedural safeguards which they contend they are being denied. They briefly mention the contention that plaintiffs should have the right to remain silent. Against this claim we must balance the practical problems plaintiffs' silence may have on psychiatric evaluation almost always needed before plaintiffs may be institutionalized. In view of these potential problems and the limited discussion of the issue in this case we think that it would be inappropriate to decide this issue at this time.

tion; (7) the rights to confront and to cross-examine witnesses against them, to offer evidence in their own behalf, and to offer testimony of witnesses.[26] Accordingly, we declare the pertinent portions of Sections 402 and 403 unconstitutional on their face and as they apply to plaintiffs and others of their class, and we enjoin the enforcement of such portions.[27]

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[26] We neither intend nor expect that all of these procedures will be required every time an attempt to institutionalize a child is made. As we found with respect to the right of the child to be present at all hearings concerning his proposed commitment, we find that, excepting the right to notice and counsel, any or all of these rights may be waived by the child and the unbiased tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them. Because there may be situations where the child either does not understand his rights or is not competent to waive them, any or all of these rights may also be waived by the child's attorney and the unbiased tribunal may accept the waiver upon a finding that the waiver is appropriate.

[27] Some courts have approached claims by children of constitutional deprivation by comparing the rights afforded adults with the rights afforded children and questioning whether there is a peculiar state interest justifying any disparity between them. See *State v. Koome*, 530 P. 2d 260 (Wash. 1975). Authority for such an approach can be gleaned from the Supreme Court's statement in *In re Gault*, at 29, that "So wide a gulf between the State's treatment of the adult and of the child requires a bridge sturdier than mere verbiage, and reasons more persuasive than cliche can provide." Since we dispose of this case under the Due Process Clause we have no occasion to address the equal protection arguments directed at the disparate treatment of children and adults.

Plaintiffs also claim they are being denied equal protection of the law since persons above the age of eighteen (18) may voluntarily admit or commit themselves to mental institutions and persons eighteen (18) years of age or younger may not. Plaintiffs, however, failed to allege that any of the named plaintiffs ever attempted voluntarily to admit or commit themselves or even that they wish to. Accordingly, we find that plaintiffs lack standing to present this claim.



The foregoing is deemed to constitute findings of fact and conclusions of law as required by F.R. Civ. P. 52 (a).

(s) John J. Gibbons,
John J. Gibbons, *C. J.*
(s) Daniel H. Huyett, 3rd,
Daniel H. Huyett, 3rd, *D. J.*

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IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

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Civil Action No. 72-2272

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Kevin Bartley, et al.

vs.

Jack B. Kremens, individually and as Hospital Director of Haverford State Hospital, et al.

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ORDER

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NOW, July 24, 1975, IT IS ORDERED that judgment is entered in favor of plaintiffs and against defendants. Counsel for the parties shall confer and submit an appropriate form of Order consistent with this Opinion within twenty (20) days.

(s) John J. Gibbons,
John J. Gibbons, *C. J.*
(s) Daniel H. Huyett, 3rd,
Daniel H. Huyett, 3rd, *D. J.*

Re: Kevin Bartley, et al. v. Jack B. Kremens, et al. Civil
Action No. 72-2272

BRODERICK, D.J., *dissenting.*

It appears to me that the majority opinion has prescribed "an overdose" of due process which could prove fatal to the voluntary commitment of children for in-patient treatment for mental or emotional disorders. The majority opinion declares unconstitutional §§402 and 403 of the Pennsylvania Mental Health and Mental Retardation Act which provides that parents may make application for voluntary admission and commitment of their child age 18 or younger to a facility for examination, treatment and care. The due process procedure prescribed by the majority opinion for all voluntary admissions and commitments of juveniles 18 years of age and younger is as follows: (1) a probable cause hearing within 72 hours from the time of their initial detention; (2) a post-commitment hearing within 2 weeks of their initial detention; (3) written notice to the child stating the time and place of the hearing and the grounds for the proposed commitment. The notice must also be sent to the child's attorney; (4) counsel at all significant stages of the commitment process and, if indigent, the right to the appointment of free counsel; (5) the right of the child to be present at all hearings concerning his proposed commitment; (6) a finding, by "clear and convincing proof", that the child is in need of institutionalization; and (7) the right to confront and to cross-examine witnesses, and to offer evidence on his own behalf.

The Pennsylvania Mental Health and Mental Retardation Act and the regulations promulgated thereunder



provide for the voluntary admission[1] or commitment[2] of persons eighteen years of age or younger by a parent, guardian or individual standing in loco parentis to the person to be admitted. It is this voluntary admission or commitment procedure which the majority has declared unconstitutional. In effect, the majority has declared that no voluntary commitment of children by their parents can meet the constitutional requirements of the Fourteenth Amendment.

Under the Pennsylvania Act and regulations, application for voluntary admission or commitment[3] to a facility may be made by a parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years or younger.[4] In order to be admitted or committed to an institution, any person aged 18 and younger must first be referred from a recognized medical facility, Mental Health/Mental Retardation therapist or Mental Health Agency. Such referral must be accomplished by a psychiatric evaluation and a report which states with specificity the reasons that the child requires institutional care. After such referral, the director of the facility to which the parents seek to have their child admitted must then conduct an independent examination

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[1] 50 P.S. §4402(a)(2).

[2] 50 P.S. §4403(a)(2).

[3] The legislature chose to pass two distinct statutes, one of which deals with voluntary admissions to a facility while the other is concerned with voluntary commitments. Apparently, the main distinction in the two statutes is that under the later section dealing with voluntary commitments, the initial commitment is for a period not to exceed thirty days, with successive periods not to exceed thirty days each, so long as care or observation is necessary. The section providing for voluntary admissions contains no corresponding time limitation following admission to a facility.

[4] 50 P.S. §4402(a)(2); 50 P.S. §4403(a)(2).

of the child in order to determine whether the child is in need of institutional care or observation. If the director's independent examination disagrees with the referring professional's opinion, the child cannot be institutionalized. In the case of a voluntary commitment under §403 of the Act, an acceptance for commitment may not exceed thirty days without a successive application for continued voluntary commitment for an additional thirty day period.[6] In the case of juveniles 13 years of age and older, within 24 hours of admission to the institution, the juvenile must be given written notification which he signs and which is to be fully explained to him and which states that he will be furnished with counsel to represent him. Should a juvenile who is 13 years of age or older object, either orally or in writing, to remaining in the institution, the director, if he feels it is necessary for the youth to remain, may continue the institutionalization for two business days, during which time notification shall be made to the applicant and the referral unit so that either party may institute a §406 proceeding, which is the statutorily required court hearing for an involuntary commitment. During that same two day period, the director must obtain counsel to represent the juvenile. The juvenile's counsel is then furnished with the evaluation of the juvenile by the referral unit, a psychiatric evaluation from the institution, and a written report of the reasons that the institution feels that institutionalization is required.[7]

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[5] 50 P.S. §4402(b); 50 P.S. §4403(b). [No corresponding text citation]

[6] 50 P.S. §4403(b).

[7] I agree with the majority that these regulations which provide for instituting a §406 hearing do not provide for a period within which such a hearing shall be held following the objection of the child to remaining in the institution.



The effect of the Act and the regulations promulgated thereunder is that two independent medical opinions must concur in a recommendation of institutionalization before a minor can be voluntarily admitted. In the case of juveniles 13 and over, upon their objection to remaining in the institution, future institutionalization must proceed pursuant to the civil court commitment provisions of the Act (Section 406). Section 406 provides the procedure for an involuntary civil court commitment and requires the filing of a petition with the Court of Common Pleas, pursuant to which the Court issues a warrant requiring the allegedly ill person to be brought to Court for a hearing. Counsel appointed for the juvenile represents him at the hearing before the Court of Common Pleas. After the hearing, the Court may order an examination by two physicians or order commitment for a period not to exceed ten days for an examination, after which commitment may be ordered by the Court. Plaintiffs do not attack the constitutionality of the civil court commitments under §406 of the Act which follow the above outlined procedure.

I do not take the position that children have no rights. I simply feel that the procedures outlined by the Pennsylvania Legislature, when balanced against the traditional rights of parents to control the rearing of their children, afford sufficient protection to the child. The present Act does not permit a parent who seeks to admit a child under §402 or §403 to simply hand over the child to the institution. Two psychiatrists must agree, after an examination, that the child is in need of institutionalization. In the case of a voluntary commitment, a periodic review must be performed by the director every thirty days to determine whether continued institutionalization is necessary. And in the case of a juvenile thirteen years

of age and older, the juvenile is entitled to a hearing with counsel concerning his need for institutionalization following his objection. The majority in this case holds that all children are constitutionally entitled to a similar type of hearing within two weeks of their institutionalization. The only group for which the present regulations have not provided a hearing subsequent to their being received in the institution are those children 12 years of age and under. Because of this alleged defect, the majority declares §402 and §403 unconstitutional.

It is now a well settled principle that "due process 'is an elusive concept', the content of which 'varies according to specific factual contexts.'" *Hannah v. Larche,* 363 U.S. 420, 442 (1960); *Logan v. Arafeh,* 346 F. Supp. 1265, 1268 (D. Conn. 1972).

> [C]onsideration for which procedures due process may require under any given set of circumstances must begin with a determination of the precise nature of the government function involved as well as the private interest that has been affected by government action. *Cafeteria and Restaurant Workers Union, Local 473, AFL-CIO v. McElroy,* 367 U. S. 886, 895 (1961).

Due process of law does not require a hearing in every conceivable case of government impairment of private interest. *Stanley v. Illinois,* 405 U. S. 695 (1972).

An evaluation of the competing interest involved in this case leads me to the conclusion that §402 and §403 of the Act and the regulations thereunder are constitutional on their face. Without minimizing the interest of a child



12 years and under to be free from a wrongful and unwarranted deprivation of his liberty, the traditional interest of the state in preserving the family unit and in maintaining parental control over their young children is such that the strict procedural due process requirements imposed by the majority holding as to "voluntary" commitments are not required by the Fourteenth Amendment.

The Supreme Court has repeatedly recognized and afforded great weight to the rights of parental control and custody of their children and has given due respect to the powerful role of the familial relationship in our democratic society. This substantial interest of parents undeniably warrants deference and, absent a powerful countervailing interest, warrants protection. It is plain that the interest of family integrity and the interests of parents in the care, custody and nurture of their children come to the court with a momentum deserving of respect. *Kovacs v. Cooper,* 336 U. S. 77, 95 (1949) (Frankfurter, J., concurring).

As the Supreme Court stated in *Stanley v. Illinois,* 405 U. S. 645, 651 (1972):

> The Court has frequently emphasized the importance of the family. The rights to conceive and to raise one's children have been deemed "essential," Meyer v. Nebraska, 262 U. S. 390, 399, 43 S. Ct. 625, 626, 67 L. Ed. 1042 (1923), "basic civil rights of man," Skinner v. Oklahoma, 316 U. S. 535, 541, 62 S. Ct. 1110, 1113, 86 L. Ed. 1655 (1942), and "[r]ights far more previous . . . than property rights," May v. Anderson, 345 U. S. 528, 533, 73 S. Ct. 840, 843, 97 L. Ed. 1221 (1953). "It is cardinal with

> us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder." Prince v. Massachusetts, 321 U. S. 158, 166, 64 S. Ct. 438, 442, 88 L. Ed. 645 (1944). The integrity of the family unit has found protection in the Due Process Clause of the Fourteenth Amendment, Meyer v. Nebraska, *supra,* 262 U. S. at 399, 43 S. Ct. at 626, the Equal Protection Clause of the Fourteenth Amendment, Skinner v. Oklahoma, *supra,* 316 U. S., at 541, 62 S. Ct. at 1113, and the Ninth Amendment, Griswold v. Connecticut, 381 U. S. 479, 496, 85 S. Ct. 1678, 14 L. Ed. 2d 510 (1965) (Goldberg, J., concurring).

The authorities cited above make it clear that the parents' interest in directing the upbringing of their children is cognizable and substantial. *Stanley, supra* at 652. Those who nurture the child and direct his destiny have the right coupled with the high duty, to recognize and prepare him for additional obligations. *Pierce v. Society of the Sisters of the Holy Names, etc.,* 268 U. S. 510, 535 (1925). The parents' claim to authority in their own household to direct the rearing of their children has been termed "basic to the structure of our society." *Ginsberg v. State of New York,* 390 U. S. 629, 639 (1968). In *Wisconsin v. Yoder,* 406 U. S. 205 (1972), the Supreme Court stated at 232:

> The history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children. This primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition.



As Chief Judge Bazelon of the District of Columbia Court of Appeals has stated:

> [T]he family is the most effective child-developing agent around, when it wants to be and can be. Out of the plethora of studies of day care and early intervention, one thing stands out: a child needs most a family—it is there that he finds his roots and his education. Mothers and fathers who spend time with their child are better at it than are most organized group care arrangements. David L. Bazelon, *Whose Needy Children?* University of Michigan Journal of Law Reform, vol. 8, 247.

Simply stated, it is my opinion that the present Act and the regulations thereunder which require two independent psychiatric evaluations recommending institutionalization before a parent can voluntarily have his child admitted for treatment or observation provides sufficient protection to the child against an unwarranted or unjustified institutionalization.

The record in this case demonstrates that most parents act in the best interests of their child when making the decision to voluntarily submit their child to institutional treatment. Indeed, those parents whose motives the majority opinion questions are few and far between. Children of the age of twelve and younger are at a stage of development when parents must have direct control over their care and treatment. Parents of such young children are best able to make a determination as to their child's needs, and their decision to seek institutional care and treatment for their child comes only after all other alternatives for treatment and care have been exhausted. To pro-

tect a child from being institutionalized when not in need of such care, the State has developed a system whereby the independent judgment of two experts, trained in this difficult area, must concur with the parents' decision. [8]

As the record in this case clearly reveals, the modern trend in the treatment of the mentally and emotionally ill and the retarded is to institutionalize for the least amount of time and only when all else has failed. The majority opinion expressed concern as to the warehousing of children which might result from the voluntary commitment procedure. However, since the recent opinion of the Supreme Court in *O'Conner v. Donaldson,* 43 U.S.L.W. 4929 (1975), this fear should be dissipated by the Court's holding that a state cannot constitutionally confine a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends. I find that the procedures set forth by the majority which require two hearings with counsel appointed for the child, the confrontation and cross-examination of parents and the requirement of clear and convincing proof of the need of institutional care needlessly destroys the voluntary commitment procedure without affording any significant protection for the child. The adversary nature of the procedure which the

[8] I am aware that courts in Nebraska and Tennessee have declared unconstitutional statutes which permit the voluntary institutionalization of children. *Horacek, etc. v. Exon, et al.,* Civil Action No. 74-L-299 (D.C. Neb. 1974). *Saville v. Treadway,* Civil Action No. 6969 (M.D. Tenn. 1974). However, it is not apparent from reading the opinions in those cases whether both Nebraska and Tennessee provide a protective procedure similar to those provided for under the Pennsylvania statute and regulations.



majority requires will significantly increase the trauma which accompanies the institutionalization of sick children and will further serve to stigmatize the recipient of the court endorsed commitment. In my opinion, it retards society's progress of recent years in encouraging parents to seek treatment and care of a child in need of hospitalization for a mental or emotional disorder. It will likewise retard society's progress toward removing the stigma still associated by some with psychiatric care. The majority opinion discusses "the stigma associated with civil commitment", yet sets up a system which makes civil commitment necessary. For years now, responsible leaders have been counseling the public that treatment for mental and emotional disorders should be as readily available and as readily acceptable as hospitalization for a tonsillectomy or appendectomy. It certainly will not encourage parents to seek hospitalization for a mentally or emotionally disturbed child when the parent learns that counsel will be appointed for the child and that there will be an adversary hearing at which parents will be subjected to cross-examination as to their motives for seeking hospitalization.

PLAINTIFFS' PROPOSED ORDER—AUGUST 5, 1975

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

CIVIL ACTION No. 72-2272

Kevin Bartley, et al., by their guardian ad litem, David Ferleger, Esquire,

Plaintiffs

v.

Jack B. Kremens, individually and as Hospital Director of Haverford State Hospital, et al.,

Defendants

ORDER OF JUDGMENT

The opinion in this case was released July 24, 1975 along with our order granting judgment in favor of plaintiffs and against defendants. Pursuant to Rules 58 and 65 (d) of the Federal Rules of Civil Procedure, the following order is hereby entered to provide the declaratory and injunctive relief to which the Court in its opinion held plaintiffs entitled and to implement said opinion:

It is ordered that final judgment in favor of all plaintiffs and the class they represent and against defendants Jack B. Kremens, M.D., individually and as Hospital Director of Haverford State Hospital; Helene Wohlgemuth, individually and as Secretary of the Department of Public



Welfare of Pennsylvania; William B. Beach, Deputy Secretary of Mental Health and Mental Retardation, and their officers, agents, employees, servants and their successors and those acting in active concert or participation with them, is hereby granted and ordered entered as follows:

CLASS ACTION

1. This action is properly maintained as a class action under Fed. R. Civ. P. 23 (b) (2). The class represented by the named plaintiffs are all persons eighteen years of age or younger who have been, are, or may be admitted or committed to mental health facilities in Pennsylvania under the Pennsylvania Mental Health and Mental Retardation Act of 1966 (hereafter, "Act"). 50 P.S. §§4402 and 4403 (§§402 and 403). In this order, the class or its members are occasionally referred to as "child-(ren)", "juvenile (s)" or "subject (s) of the proceeding (s)".

DECLARATORY JUDGMENT

2. The Pennsylvania civil commitment statutes contained at 50 P.S. §§4402 (a) (2) and 4403 (a) (2) are hereby declared to be unconstitutional on their face and as applied under the Due Process Clause of the Fourteenth Amendment to the United States Constitution.

3. The Pennsylvania civil commitment statute contained at 50 P.S. §4402 (c) is hereby declared to be unconstitutional on its face and as applied under the Due Process Clause of the Fourteenth Amendment to the United States

Constitution, except for the phrase in that statute, "any person voluntarily committed shall be free to withdraw at any time."

*Notice*

4. The above statutes are declared invalid in that they fail to require that members of the class receive written advance notice of the date, time and place of the hearings on a proposed commitment, along with a statement of the grounds for the proposed commitment. In addition, it is declared that the child's attorney must be in receipt of this notice at least forty-eight (48) hours prior to the initial hearing.

5. Until such time as some other proper procedure is established by the legislature in accordance with this Court's opinion and order, it is declared that this notice (in addition to the requirements of Paragraph 4 above) must be sent not only to the child but also to the Clerk of the Court with jurisdiction and must be forwarded to the child's attorney.

*Counsel*

6. The above statutes are declared invalid in that they fail to require counsel for the child and, if indigent, appointment of free counsel, during all significant stages of the commitment process.

*Presence of Person*

7. The above statutes are declared invalid in that they fail to require for persons subject to the proceedings the right to presence with counsel, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, opportunity to offer evidence on their own behalf and to offer the testimony of witnesses.



*Standard of Proof*

8. The above statutes are declared invalid in that they fail to require that the fact finder, in a hearing on commitment of a juvenile, must find by clear and convincing proof that the subject is in need of institutionalization.

*Probable Cause Hearing*

9. The above statutes are declared invalid in that they permit detention of members of the class for periods in excess of seventy-two (72) hours without a hearing to test whether there is probable cause to believe institutionalization is necessary. It is further declared that in no event shall detention of the child in the absence of a probable cause hearing exceed seventy-two (72) hours from the date of the initial detention.

10. The above statutes are declared invalid in that they fail to provide at a probable cause hearing the rights described in Paragraphs 4 through 8 above and in Paragraph 18 below.

*Commitment Hearing*

11. The above statutes are declared invalid in that they fail to require that, if the conclusion of the probable cause hearing is that there is probable cause for believing the child needs institutionalization, the child is entitled to a full hearing on the need for commitment. It is further declared that this hearing must be held within two (2) weeks from the date of the initial detention. In no event shall detention of the child in the absence of this full hearing exceed two (2) weeks from the date of the initial detention.

12. The above statutes are declared to be invalid in that they fail to provide at this commitment hearing the rights described in Paragraphs 4 through 8 above and in Paragraph 18 below.

*Regulations*

13. The regulations promulgated by Defendant Wohlgemuth with regard to §§402 and 403, published at 3 Pa. Bull. 1840, are hereby declared invalid and in violation of the Due Process Clause of the Fourteenth Amendment to the United States Constitution in that they fail to require for all members of the class the rights described in Paragraphs 4 through 12 above and in Paragraph 18 below.

*Named Plaintiffs' and Class Members' Commitments and Admissions*

14. It is hereby declared that the commitments and admissions of the named plaintiffs to Haverford State Hospital, accepted by Defendant Kremens, are unconstitutional, void and invalid.

15. It is hereby declared that the unnamed plaintiffs, all persons eighteen years of age or younger admitted or committed to mental health facilities in Pennsylvania under §§402 and 403 of the Act, are unconstitutionally held and detained.

*Use of State Courts*

16. Until the legislature acts to establish an unbiased tribunal to conduct the probable cause and final hearings as required by the opinion and order herein, it is hereby declared that the present facilities of the Commonwealth court system must be used for these hearings.



*Application for Treatment for Juveniles*

17. It is hereby declared that a parent, guardian or individual standing in loco parentis may temporarily detain a class member in a mental health facility if the procedures and requirements of this order and opinion are fully complied with. See especially Paragraphs 2 through 12 and 18.

*Requirements for Commitment*

18. It is hereby declared that all members of the class who have been, are or may be subject to admission or commitment are entitled to:

*Notice*

A. Written advance notice of the date, time and place of the hearings on a proposed commitment, along with a statement of the grounds for the proposed commitment. In addition, the child's attorney must be in receipt of this notice at least forty-eight (48) hours prior to the initial hearing.

B. Until some other proper procedure is established by the legislature in accordance with this Court's opinion and order, this notice must be sent not only to the child but also to the Clerk of the Court with jurisdiction and must be forwarded to the child's attorney.

*Counsel*

C. Counsel and, if indigent, appointment of free counsel, during all significant stages of the commitment process.

*Presence of Person, Other Hearing Rights*

D. Presence of the person subject to the proceedings, with counsel, an opportunity to be heard, confrontation

and cross-examination of adverse witnesses, opportunity to offer evidence on their own behalf and to offer the testimony of witnesses.

*Standard of Proof*

E. A finding by clear and convincing proof that the subject is in need of institutionalization.

*Probable Cause Hearing*

F. A hearing within seventy-two (72) hours from the date of the initial detention to test whether there is probable cause to believe that institutionalization is necessary.

*Commitment Hearing*

G. A full hearing within two (2) weeks from the date of the initial detention.

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INJUNCTIVE RELIEF

19. It is further ordered that the defendants and their officers, agents, servants, employees, successors and those persons in active concert or participation with them are hereby enjoined:

*Procedures*

A. To refrain from accepting or continuing the admission or commitment of any member of the class to any mental health facility unless such person is or has been provided:

1) Written advance notice of the date, time and place of the hearings on a proposed commitment, along with a statement of the grounds for the proposed commitment. In addition, the child's attorney must be in receipt of this notice at least forty-eight (48) hours prior to the initial hearing.



2) Until some other proper procedure is established by the legislature in accordance with this Court's opinion, this notice must be sent not only to the child but also to the Clerk of the Court with jurisdiction and must be forwarded to the child's attorney.

3) Counsel and, if indigent, appointment of free counsel, during all significant stages of the commitment process.

4) Presence of the person subject to the proceedings, with counsel, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, opportunity to offer evidence on their own behalf and to offer the testimony of witnesses.

5) A finding by clear and convincing proof that the subject is in need of institutionalization.

6) A hearing within seventy-two (72) hours from the date of the initial detention to test whether there is probable cause to believe institutionalization is necessary. In no event shall defendants detain the child in the absence of a probable cause hearing longer than seventy-two (72) hours from the date of the initial detention.

7) A full hearing within two (2) weeks from the date of the initial detention. In no event shall defendants detain the child in the absence of the full hearing longer than two (2) weeks from the date of the initial detention.

*Regulations*

B. To promulgate and issue regulations and to publish them within two weeks, as immediately effective, which regulations shall require that all mental health facilities in Pennsylvania (see 50 P.S. §4102 for definition of "facility") adhere to the opinion and order in this case.

*Notice of Order*

C. To give personal notice of this Court's opinion and order to all state school and mental hospital directors and their delegates, and to the directors of all other mental health facilities in Pennsylvania.

*Access for Attorneys*

D. To provide access by attorneys to the grounds and facilities of all mental hospitals and institutions, to their individual clients and to the institutional and hospital records pertaining to their clients' commitments.

*Procedures for Present Class Members*

E. To initiate procedures, commencing immediately, which shall assure that all members of the class committed or admitted pursuant to §§402 and 403 are either discharged or released pursuant to the opinion and order herein or are recommitted according to the procedures required by the opinion and order herein. Such discharge, release or recommitment shall begin immediately, shall continue and shall be concluded within forty-five (45) days of this order. Notation shall be made upon the medical records of such members of the class that their discharge, release or recommitment was pursuant to the opinion and order in this case.

*Reports on Implementation*

F. To report to the Court within thirty (30) days, and again within sixty (60) days regarding the steps taken and progress made in the implementation of this opinion and order and certifying that the required notice, publication and other steps have been accomplished and in what manner. The sixty (60) day report shall describe, for each mental health facility, the number of class members released, discharged or recommitted.



G. To pay to plaintiffs' counsel the costs herein which shall be taxed in accordance with Rule 54 F.R. Civ. P.

By the Court:

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_____

_____

DEFENDANTS' PROPOSED ORDER—AUGUST 21, 1975

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IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

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Civil Action No. 72-2272

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Kevin Bartley, et al.

v.

Jack B. Kremens, individually and as Hospital Director of Haverford State Hospital, et al.

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FINAL ORDER

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AND NOW, this day of , 1975 and, in accordance with the Opinion issued on July 24, 1975, this court enters this final order.

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CLASS ACTION

1. This action shall be maintained as a class action, pursuant to F.R.C.P. 23 (b) (2). The class represented by the plaintiffs are all persons eighteen years of age or younger (sometimes referred to as "juveniles") who have been, are, or may be admitted or committed to mental health facilities in Pennsylvania pursuant to and under the authority of the Pennsylvania Mental Health and Mental Retardation Act of 1966 and more specifically sections 402 and 403 thereof, 50 P.S. §§4402 and 4403.



DECLARATORY JUDGMENT

2. Sections 402 (a) (2), 402 (c) except the phrase "any person voluntarily committed shall be free to withdraw at any time", and 403 (a) (2) of the Mental Health and Mental Retardation Act of 1966, 50 P.S. §§4402 (a) (2), 4402 (c) except the phrase "any person voluntarily committed shall be free to withdraw at anytime", and 4403 (a) (2), are hereby declared to be repugnant to the Constitution of the United States and more particularly the Due Process Clause of the Fourteenth Amendment thereof.

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INJUNCTION

3. Except as provided in Paragraph 4, hereof, defendants shall be and are hereby enjoined and restrained from admitting or committing any person eighteen years of age or younger pursuant to or under the authority of those proportions of the Pennsylvania Mental Health and Mental Retardation Act of 1966 which have herein been declared unconstitutional.

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EQUITABLE RELIEF

4. In order to protect the rights of the classes of plaintiffs and in order to give the Generai Assembly of the Commonwealth of Pennsylvania time to determine whether new legislation shall be enacted and to determine the particulars of such new legislation and in order to equitably adjust the rights and interests of the parties in light of the immediate effect of our opinion and order and in order to insure that persons eighteen years of age and younger who desire to or need to be committed to mental

health facilities in Pennsylvania, paragraph 3 of this order is hereby stayed for a period of 180 days from the date of this order or until new legislation is enacted by the Pennsylvania General Assembly, which ever occurs first, provided however, that defendants shall be and are enjoined and restrained from accepting for admission or commitment any person eighteen years of age or younger unless the following procedural safeguards are afforded:

PROBABLE CAUSE HEARING

a. Within seventy two (72) hours[1] after the admission of a person eighteen years of age or younger a probable cause hearing, before a Court of Common Pleas, shall be held. The Court may appoint masters for the hearing in determination of such matters. The hearing judge or master shall determine, from the evidence presented that the moving party has made a prima facie showing that the juvenile is mentally ill or mentally retarded and is in need of institutionalization.

POST COMMITMENT HEARING

b. Within two weeks of the admission or commitment of a person eighteen years or younger a post-commitment hearing before a Court of Common Pleas shall be held. The Court may appoint masters for the hearing and determination of such matters. The

[1] As to admissions or commitments made on Thursday, the probable cause hearing shall be held no later than the next Monday; as to admissions or commitments made on Friday, the probable cause hearing shall be held no later than the next Tuesday; as to admissions or commitments made on a Saturday or Sunday, a probable cause hearing shall be held no later than the next Wednesday.



hearing judge or master shall determine from the evidence presented, that the moving party, by clear and convincing proof that the moving party has shown that the juvenile is mentally ill or mentally retarded and is in need of institutionalization.

COUNSEL

c. The juvenile shall be entitled to counsel at both the Probable Cause Hearing and the Post-Commitment Hearing, if indigent, the Court shall appoint counsel. The Court may, if a parent or the parents or moving party are not indigent assess counsel fees against them or any of them as justice may require. The Court may appoint the public defender, legal services organization or legal aid office as counsel for the juvenile.

NOTICE

d. Within 48 hours prior to the Post Commitment Hearing the moving party shall actually serve a notice upon, the juvenile and the clerk of court or if the juvenile is represented by counsel, such counsel. The notice shall contain the following:

1. Date, time and place of hearing

2. Statement of the grounds for the proposed commitment.

PRESENCE

e. Juveniles have the right to be present at all hearings concerning their proposed commitment. A juvenile may waive such rights.

f. Except as to the right of notice and the right of counsel, all rights set forth in Paragraph 4 hereof may be waived by the juvenile and the judge or master

may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them.

g. Except as to the right of notice and the right to counsel, all of the rights set forth in Paragraph 4 hereof may also be waived by the juveniles' counsel and the judge or master may accept the waiver upon a finding that the waiver is appropriate under the circumstances of the case.

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DISTRIBUTION

5. The Clerk of this Court shall distribute to all judges of the Courts of Common Pleas in Pennsylvania a copy of the opinions of this Court and this Order under cover of a letter of the Clerk.

6. The Clerk of this Court shall distribute to all members of the Pennsylvania General Assembly a copy of the opinions of this Court and this order under cover of a letter of the Clerk.

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John J. Gibbons *C.J.*

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Daniel H. Huyett, III *J.*



COURT'S PROPOSED ORDER—SEPTEMBER 16, 1975

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IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

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Civil Action No. 72-2272

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Kevin Bartley, et al.

vs.

Jack B. Kremens, Individually and as Hospital Director of Haverford State Hospital, et al.

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ORDER

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Before Honorable John J. Gibbons, Circuit Judge, and Honorable Daniel H. Huyett, 3rd, and Honorable Raymond J. Broderick, District Judges

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HUYETT, J. September , 1975

On July 24, 1975, we filed our opinion and order in this action granting judgment in favor of plaintiffs and against defendants. Pursuant to Fed. R. Civ. P. 58 and 65 (d), we now enter the following Order to provide and implement the declaratory and injunctive relief to which we held plaintiffs entitled in our opinion.

CLASS ACTION

1. This action is properly maintained as a class action under Fed. R. Civ. P. 23(b)(2). The class represented by the named plaintiffs includes all children eighteen years of age or younger who have been, are, or may be admitted or committed to mental health facilities in Pennsylvania under the Pennsylvania Mental Health and Mental Retardation Act of 1966. 50 P.S. §§4402 and 4403 (§§402 and 403).

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DECLARATORY JUDGMENT

2. Section 402(a)(2), section 402(c), except for the language "any person voluntarily admitted shall be free to withdraw at any time," and section 403(a)(2) of the Pennsylvania Mental Health and Mental Retardation Act (Act) are declared to be unconstitutional on their face and as applied under the due process clause of the Fourteenth Amendment to the United States Constitution.

*Notice*

3. These sections of the Act are declared invalid in that they fail to require that children eighteen years of age or younger receive prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the child's attorney must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the legislature establishes some other procedure consonant with our opinion and order, it is declared that this notice must be sent not only to the child but also the Clerk of the Court with jurisdiction to be forwarded to the child's attorney.



*Counsel*

4. These sections of the Act are declared invalid in that they fail to require during all significant stages of the commitment process counsel for children eighteen years of age or younger and, if the child is indigent, appointment of free counsel.

*Presence of Child*

5. These sections of the Act are declared invalid in that they fail to afford to children eighteen years of age or younger subject to commitment hearings the rights to presence with counsel, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and the opportunity to offer the testimony of witnesses and other evidence on their own behalf.

*Standard of Proof*

6. These sections of the Act are declared invalid in that they fail to require that the fact finder in a full hearing on the commitment of a child eighteen years of age or younger find by clear and convincing proof that the child is in need of institutionalization.

*Probable Cause Hearing*

7. These sections of the Act are declared invalid in that they permit detention of children eighteen years of age or younger for more than seventy-two (72) hours without a hearing to test whether there is probable cause to believe institutionalization is necessary. These sections of the Act are further declared invalid in that they fail to provide at a probable cause hearing the rights delineated in paragraphs 3 through 5 above.

*Full Commitment Hearing*

8. These sections of the Act are declared invalid in that in the event the initial hearing determines the existence of probable cause, they fail to afford to children eighteen years of age or younger a full hearing on the need for commitment within two weeks from the date of initial detention. These sections of the Act are further declared invalid in that they fail to provide at a full commitment hearing the rights delineated in paragraphs 3 through 6 above.

*Regulations*

9. The regulations promulgated by defendant Wohlgemuth to supplement these sections of the Act, published at 3 Pa. Bull. 1840, are declared invalid and in violation of the due process clause of the Fourteenth Amendment to the United States Constitution in that they fail to require for all children eighteen years of age or younger the rights delineated in paragraphs 3 through 8 above.

*Admissions and Commitments of Plaintiffs*

10. It is declared that all children eighteen years of age or younger admitted or committed to mental health facilities in Pennsylvania under these sections of the Act are unconstitutionally held and detained.

*Use of State Courts*

11. Until the legislature establishes in accord with our opinion and orders an alternate neutral tribunal to conduct the probable cause and full commitment hearings, it is declared that the present facilities of the Commonwealth court system be used for these hearings.



*Application for Treatment of Juveniles*

12. It is declared that a parent, guardian, or person standing in loco parentis may initiate the temporary detention of a child eighteen years of age or younger in a mental health facility if the procedures and requirements of our opinion and order are fully complied with.

*Requirements for Commitment*

13. It is declared that all children eighteen years of age or younger who have been, are, or may be subject to admission or commission to a mental health facility in Pennsylvania are entitled to:

*Notice*

A. Prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the child's attorney must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the legislature establishes some other procedure consonant with our opinion and order, this notice must be sent not only to the child but also to the Clerk of the Court with jurisdiction to be forwarded to the child's attorney.

*Counsel*

B. Counsel during all significant stages of the commitment process and, if the child is indigent, appointment of free counsel.

*Presence of Child and Other Hearing Rights*

C. Presence of the child at all commitment hearings, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the child's behalf.

*Standard of Proof*

D. A finding by clear and convincing proof at the full commitment hearing that the child is in need of institutionalization.

*Probable Cause Hearing*

E. A hearing within seventy-two (72) hours from the date of the initial detention to test whether or not there is probable cause to believe that institutionalization is necessary.

*Full Commitment Hearing*

F. A full commitment hearing within two (2) weeks from the date of the initial detention.

*Waiver*

14. Excepting the rights to notice and counsel, any or all of the rights delineated in paragraph 13 may be waived by the child, and the neutral tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them. Because there may be situations where the child either does not understand his rights or is not competent to waive them, any or all of these rights, excepting notice and counsel, may also be waived by the child's attorney, and the neutral tribunal may accept the waiver upon a finding that the waiver is appropriate.

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INJUNCTIVE RELIEF

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15. It is ordered that the operation of section 402 (a) (2), section 402 (c), except for the language "any person voluntarily admitted shall be free to withdraw at any



time," and section 403 (a) (2) of the Pennsylvania Mental Health and Mental Retardation Act (Act) is enjoined in that these sections of the Act are unconstitutional on their face and as applied under the due process clause of the Fourteenth Amendment to the United States Constitution. It is further ordered that the defendants and their officers, agents, servants, employees, successors, and those persons in active concert or participation with them are enjoined:

*Procedures*

A. To refrain from accepting or continuing the admission or commitment of any child eighteen years of age or younger under the Act to any mental health facility unless the child is or has been provided:

(1) Prior written notice of the date, time and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the child's attorney must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the legislature established some other procedure consonant with our opinion and order, this notice must be sent not only to the child but also to the Clerk of the Court with jurisdiction to be forwarded to the child's attorney.

(2) Counsel during all significant stages of the commitment process and, if the child is indigent, appointment of free counsel.

(3) Presence of the child at all commitment hearings, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the child's behalf.

(4) A finding by clear and convincing proof at the full commitment hearing that the child is in need of institutionalization.

(5) A hearing within seventy-two (72) hours from the date of the initial detention to test whether or not there is probable cause to believe that institutionalization is necessary.

(6) A full commitment hearing within two (2) weeks from the date of the initial detention.

Excepting the rights to notice and counsel, any or all of the rights delineated in paragraph 15(A) may be waived by the child, and the neutral tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them. Because there may be situations where the child either does not understand his rights or is not competent to waive them, any or all of these rights, excepting notice and counsel, may also be waived by the child's attorney, and the neutral tribunal may accept the waiver upon a finding that the waiver is appropriate.

*Regulations*

B. To promulgate and issue regulations and to publish them, within thirty (30) days as immediately effective, requiring that all mental health facilities in Pennsylvania (*see* 50 P.S. §4102 for the definition of "facility") adhere to the opinion and order in this action.

*Notice of Order*

C. To give notice forthwith to all state school and mental hospital directors and their delegates and all



directors of all other mental health facilities in Pennsylvania of the opinion and order in this action. Further, to give notice forthwith to all judges of the Courts of Common Pleas in Pennsylvania of the opinion and order in this action.

*Access for Attorneys*

D. To provide to attorneys access to the grounds and facilities of all mental hospitals and institutions, to their individual clients, and to the institutional and hospital records pertaining to their clients' commitments.

*Procedures for Children Already Admitted or Committed*

E. To initiate procedures, commencing immediately, to assure that all children eighteen years of age or younger already admitted or committed pursuant to §§402 and 403 are either discharged or released or recommitted according to the procedures required by our opinion and order. Such discharge, release, or recommitment shall begin immediately and shall be concluded within one hundred and twenty (120) days of the date of this order. Notation shall be made upon the medical records of such children that their discharge, release, or recommitment was effected pursuant to the opinion and order in this action.

*Reports on Implementation*

F. To report to this Court within sixty (60) days and again within one hundred and fifty (150) days on the steps taken and progress made in the implementation of our opinion and order. The one hundred and fifty-day report shall describe, for each mental health facility, the

number of children eighteen years of age or younger released, discharged, or recommitted.

_____

*C.J.*

_____

*D.J.*

_____

*D.J.*



**DEFENDANTS' EXCEPTIONS TO COURT'S PROPOSED ORDER—OCTOBER 17, 1975**

**IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA**

**Civil Action No. 72-2272**

**Kevin Bartley, et al.,**

**Plaintiffs**

**v.**

**Jack B. Kremens, et al.,**

**Defendants**

## EXCEPTIONS TO PROPOSED ORDER

The Defendants by their counsel, Barry A. Roth, Assistant Attorney General, hereby take exceptions pursuant to Federal Rule of Civil Procedure 46 to the Proposed Order which was issued in the above-captioned matter on or about the 16th day of September, 1975, and make the following representations:

1. The Opinion in this matter was issued on July 24, 1975. (Exhibit A) (22a).

2. A dissenting opinion in this matter was issued on August 7, 1975. (Exhibit B) (52a).

3. Pursuant to This Honorable Court's instruction, Defendants submitted a proposed form of final order (attached hereto as Exhibit C and made a part hereof) (72a) together with an accompanying letter dated August 21, 1975 (attached hereto as Exhibit D and made a part hereof).

4. Pursuant to This Honorable Court's instruction, Plaintiffs submitted a proposed form of final order (attached hereto as Exhibit E and made a part hereof) (62a) together with an accompanying letter dated August 5, 1975 (attached hereto as Exhibit F and made a part hereof), and in addition, a response letter to Defendants' August 21, 1975 letter (see Exhibit D) (attached hereto as Exhibit G and made a part hereof).

5. This Honorable Court submitted a proposed order to all counsel of record for comment (attached hereto as Exhibit H and made a part hereof) (77a).

6. Defendants hereby propound the following exceptions to This Honorable Court's proposed order (see Exhibit H):

A. Paragraph 3 requires that a child's attorney must receive notice of the probable cause hearing or post-commitment hearing 48 hours prior to that hearing; however, there is no method by which the Commonwealth, and in particular the Pennsylvania Department of Public Welfare can even attempt to assure that an attorney who is not yet appointed or selected will be in receipt of that notice.

B. Paragraph 3 requires that notice be sent to the child and the clerk of courts for forwarding to the child's attorney and that a probable cause hearing



be held within 72 hours from the date of the child's detention. However, the proposed order does not establish if the child may be detained in the event the child's attorney is not appointed within the 72-hour period. The Opinion, however, states, "in no event shall detention of the child in the absence of a probable cause hearing exceed seventy-two (72) hours from the date of the initial detention." (Exhibit A, p. 16).

C. Paragraph 3 requires notice to be sent by, we assume, the Department of Public Welfare to the Court who, in turn, sends it to counsel for the child, and this must be accomplished within 24 hours of the child's admission. The Department cannot assure that an unknown attorney will receive notice of the child's admission 48 hours prior to the probable cause hearing and 24 hours after the juvenile was admitted; however, address has not been made, if the conditions above were met, if an attorney can adequately prepare his case within 24 hours before the hearing.

D. Paragraph 3 requires notice of the child's admission/commitment be sent to the clerk of the court with jurisdiction; however, is jurisdiction to be determined by the location of the institution or by the county from which the child came?

E. Paragraph 3 fails to provide notice to the parent, guardian, or juvenile's applicant.

F. No provision has been made for a continuance, either by the juvenile, parent, hospital, or master.

G. Paragraphs 5 through 8 and 13 require legal representation for the juvenile. The Commonwealth does not object to representation of children by attorneys; however, in light of *Edleman v. Jordan,* this proposed order compels the State to expend funds from its treasury to pay for counsel for indigent juveniles without legislative authority and appropriations. Our order suggests that the public defender or an alternative organization like community legal services which have statutory or clear grant responsibility to accept as clients all who fall within economic guidelines, be referred the cases of indigent juveniles. No standards of indigency have been set forth and a serious question arises if the parent must pay for counsel to his child. Otherwise, until the Legislature provides an alternative source of counsel for indigent juveniles involved in these types of proceedings, it would be unlawful for This Court to order the Commonwealth to pay for said attorneys.

H. Paragraph 11 designates the Commonwealth Court system as the judicial system for the probable cause and full commitment hearings. This Court is thus creating a cause of action in a separate judicial system without a present legislative or common law foundation. As of October 2, 1975, in an amended petition of writ of habeas corpus, petitioner seeks to have declared Section 408 of the Mental Health and Mental Retardation Act of 1966 unconstitutional because there is a violation of equal protection according to the procedural requirements set forth in *Bartley. In re Bingman,* Common Pleas Court of Snyder County, No. 496, 1975. It is unclear and a matter of substantial controversy whether a



Federal District Court has the authority under the Constitution of the United States or any act of Congress to exercise such direction and control over the Commonwealth's judicial branch of government and its judicial officers.

I. In paragraph 11 This Honorable Court declares that the present facilities of the Commonwealth Court system be used for these hearings and directs that the Legislature order an alternate neutral tribunal to conduct probable cause and full commitment hearings (Exhibit H, p. 4). However, This Honorable Court fails to realize that the Legislature may provide for an equally constitutional method other than by using the Commonwealth Court system, such as the use of a masters (which is prevalent in the 406 commitment process).

J. Paragraphs 13 and 15 provide the child with an opportunity to offer testimony of witnesses; however, who bears the expense for professional testimony such as psychiatric or psychological testimony? This requirement compels the State to expend funds from its treasury to pay for services which are in direct violation of *Edleman v. Jordan.*

K. Paragraph 15(E) requires the discharge, release, or recommitment of institutionalized juveniles to be accomplished within 120 days from the date of this order. This Honorable Court is without jurisdiction and without authority to order the release or conditional release of juveniles already in custody at State institutions within the context of this civil rights action. The exclusive method by which such relief may be obtained is habeas corpus. Further, pursuant to 28 U.S.C. §2254(b), exhaustion

of state remedies is a prerequisite to federal jurisdiction in habeas corpus proceedings. The presentation of a civil rights claim requires no such exhaustion; however, it is not permissible to pursue a habeas corpus remedy through a civil rights action and thus avoid the necessity of referring to the state judicial system for habeas corpus. *Preiser v. Rodriguez,* 411 U.S. 475 (1973).

L. Paragraph 15(E) requires the discharge, release, or recommitment of all juveniles within 120 days from the date of this order. As previously stated, This Court is without jurisdiction and authority to order the release or conditional release of juveniles already in custody at state institutions within the context of this civil rights action. The exclusive method by which such relief may be obtained is habeas corpus. *Preiser v. Rodriguez,* 411 U.S. 475 (1973). The Department cannot programmatically effectuate the Court's requirement to recommit all institutionalized juveniles within 120 days and will have no choice but to discharge this group which approximates 7,000 juveniles to their parents and guardians. No aftercare is provided. The effect of this requirement will cause great harm to this class, the majority of which are severely retarded. Furthermore, discharge in several instances may not occur because parents may refuse to have their child returned to them and appropriate proceedings before the local court will be needed to effectuate appointment of a guardian ad litem for the child.

M. Paragraph 15(E) requires the discharge, release, or recommitment of all juveniles within 120 days from the date of this order. As previously



stated, This Court is without jurisdiction and authority to order the release or conditional release of juveniles already in custody at state institutions within the context of this civil rights action. The exclusive method by which such relief may be obtained is habeas corpus. *Preiser v. Rodriguez,* 411 U.S. 475 (1973). It is recommended that notation of each child's condition be made upon the child's medical record and forwarded to a guardian ad litem to be appointed by This Honorable Court for the express purpose of seeking a writ of habeas corpus action for each child whom the guardian ad litem feels is inappropriately institutionalized. More than 7,000 juveniles are currently located in State mental hospitals, State schools and hospitals, private licensed facilities, etc., and the majority of these children are severely retarded thereby making them incapable of exercising any judgment regarding their commitment.

N. Paragraph 15(F) requires time limits. It is impossible to implement some or all of the requirements of This Court's proposed order within the time indicated for reporting on implementation. Legislative authority is requisite to most, if not all of the proposed procedures required by paragraph 15 of the proposed order. Since the Legislature convened only for a brief session in September and October, and does not reconvene until after the general election in November, at least 180 days from the issuance of the final order is necessary for the Legislature to authorize implementation of appropriate procedures. The Department of Public Welfare has discussed and sent to Senator Louis Coppersmith copies of the Court's Opinion and our exceptions thereto for introducing legislation.

O. An affidavit by Stanley Meyers, Deputy Secretary for Mental Retardation, setting forth the difficulties of implementing This Court's proposed order is attached as Exhibit I.

P. An affidavit by Dr. James Harris, Deputy Secretary for Mental Health and Medical Services and Commissioner of Mental Health, sets forth the difficulties of implementing This Court's proposed order and is attached as Exhibit J.

Q. The proposed order erroneously makes no provision allowing for the continuation of the "respite care" program or the intensive training program within the Mental Health/Mental Retardation program of the Commonwealth.

R. The Pennsylvania Court Administrator has informed us that he will be writing to the Court and excepting to the proposed order. He is a necessary party to these proceedings and the Commonwealth subscribes to his objections insofar as they effect the Commonwealth.

S. Paragraph 15(F) requires us to submit reports within 60 days and within 150 days a report of our progress and implementation of the proposed order. It is impossible for the reasons mentioned heretofore to accomplish the structure set forth by This Honorable Court within the time limits. Accordingly, we submit that progress reports be afforded to This Honorable Court every three months until accomplishment of the order occurs, and at that time a full report setting forth the number of children 18 years of age or younger who are committed pursuant to Sections 402 and 403 of the Act.



7. General Exceptions

A. This Court is without jurisdiction and without authority to order the release or conditional release of juveniles already in custody at State institutions within the context of this civil rights action. The *exclusive method* by which such relief may be obtained is habeas corpus. Further, pursuant to 28 U.S.C. 2254(b), exhaustion of state remedies is a prerequisite to federal jurisdiction in habeas corpus proceedings. The presentation of a civil rights claim requires no such exhaustion; however, it is not permissible to pursue a habeas corpus remedy through a civil rights action and thus avoid the necessity of referring to the state judicial system for habeas corpus. *Preiser v. Rodriguez*, 411 U.S. 475 (1973). Additionally, Plaintiffs never sought release of juveniles in State mental health facilities.

B. This Court's proposed order compels the State to expend funds from its treasury to pay for counsel for indigent juveniles without legislative authority and appropriations. This action is in direct violation of *Edleman v. Jordan*, 415 U.S. 651 (1974).

C. It is unclear and a matter of substantial controversy whether a Federal District Court has the authority under the Constitution of the United States or any act of Congress to exercise such discretion and control over the Commonwealth's judicial branch of government and its judicial officers. Thus, This Court, in essence, has created a cause of action in a separate judicial system without a present legislative or common law foundation. To wit, an amended petition of writ of habeas corpus has been filed in the Common Pleas Court of Snyder County, No. 496,

1975 term, in which petitioner seeks to have declared unconstitutional Section 408 of the Mental Health and Mental Retardation Act of 1966 because there is a violation of equal protection according to the procedural requirements set forth in *Bartley. In re Bingaman.*

D. While there may have been evils within existing State laws, it is case legend that the protection afforded is a matter for legislative judgment. Consequently, it would be improper to have a permanent order substitute for legislative judgment *Gunn v. University Committee to End The War In Vietnam,* 399 U.S. 383 (1970); *Robinson v. Cahill,* 62 N.J. 473, 520, 521, 303 A. 2d 273, 298 (1973); *Federal Power Commission v. National Gas Pipeline Company,* 315 U.S. 575, 599, 601 (1942); *Marbury v. Madison,* 2 L. Ed 60.

Respectfully submitted,

(s) Barry A. Roth
Barry A. Roth
*Assistant Attorney General*
Paul J. Carey, Jr.
*General Counsel*
Robert P. Kane
*Attorney General*

323 Health and Welfare Building
Harrisburg, Pennsylvania 17120
(717) 787-6398
October 17, 1975



FINAL ORDER—NOVEMBER 17, 1975

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IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

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Civil Action No. 72-2272

---

Kevin Bartley, et al.

vs.

Jack B. Kremens, Individually and as Hospital Director of Haverford State Hospital, et al.

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ORDER

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Before Honorable John J. Gibbons, Circuit Judge, and Honorable Daniel H. Huyett, 3rd, and Honorable Raymond J. Broderick, District Judges

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HUYETT, J. November 17, 1975:

On July 24, 1975, we filed our opinion and order in this action granting judgment in favor of plaintiffs and against defendants. Pursuant to Fed. R. Civ. P. 58 and 65 (d), we now enter the following Order to provide and implement the declaratory and injunctive relief to which we held plaintiffs entitled in our opinion.

CLASS ACTION

1. This action is properly maintained as a class action under Fed. R. Civ. P. 23(b) (2). The class represented by the named plaintiffs includes all children eighteen years of age or younger who have been, are, or may be admitted or committed to mental health or mental retardation facilities in Pennsylvania under the Pennsylvania Mental Health and Mental Retardation Act of 1966. 50 P.S. §§4402 and 4403 (§§402 and 403).

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DECLARATORY JUDGMENT

2. Section 402(a) (2), section 402(c), except for the language "any person voluntarily admitted shall be free to withdraw at any time," and section 403(a) (2) of the Pennsylvania Mental Health and Mental Retardation Act (Act) are declared to be unconstitutional on their face and as applied under the due process clause of the Fourteenth Amendment to the United States Constitution.

*Notice*

3. These sections of the Act are declared invalid in that they fail to require that children eighteen years of age or younger receive prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the child's attorney must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the legislature establishes some other procedure consonant with our opinion and order, it is declared that this notice must be sent not only to the child but also the Clerk of the Court with jurisdiction to be forwarded to the child's attorney.



*Counsel*

4. These sections of the Act are declared invalid in that they fail to require during all significant stages of the commitment process counsel for children eighteen years of age or younger and, if the child is indigent, appointment of free counsel.

*Presence of Child*

5. These sections of the Act are declared invalid in that they fail to afford to children eighteen years of age or younger subject to commitment hearings the rights to presence with counsel, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and the opportunity to offer the testimony of witnesses and other evidence on their own behalf.

*Standard of Proof*

6. These sections of the Act are declared invalid in that they fail to require that the fact finder in a full hearing on the commitment of a child eighteen years of age or younger find by clear and convincing proof that the child is in need of institutionalization.

*Probable Cause Hearing*

7. These sections of the Act are declared invalid in that they permit detention of children eighteen years of age or younger for more than seventy-two (72) hours without a hearing to test whether there is probable cause to believe institutionalization is necessary. These sections of the Act are further declared invalid in that they fail to provide at a probable cause hearing the rights delineated in paragraphs 3 through 5 above.

*Full Commitment Hearing*

8. These sections of the Act are declared invalid in that in the event the initial hearing determines the existence of probable cause, they fail to afford to children eighteen years of age or younger a full hearing on the need for commitment within two weeks from the date of initial detention. These sections of the Act are further declared invalid in that they fail to provide at a full commitment hearing the rights delineated in paragraphs 3 through 6 above.

*Regulations*

9. The regulations promulgated by defendant Wohlgemuth to supplement these sections of the Act, published at 3 Pa. Bull. 1840, are declared invalid and in violation of the due process clause of the Fourteenth Amendment to the United States Constitution in that they fail to require for all children eighteen years of age or younger the rights delineated in paragraphs 3 through 8 above.

*Admissions and Commitments of Plaintiffs*

10. It is declared that all children eighteen years of age or younger admitted or committed to mental health or mental retardation facilities in Pennsylvania under these sections of the Act are unconstitutionally held and detained.

*Use of State Courts*

11. Until the legislature establishes in accord with our opinion and order an alternate neutral tribunal to conduct the probable cause and full commitment hearings, it is declared that the present facilities of the Commonwealth court system be used for these hearings.



*Application for Treatment of Juveniles*

12. It is declared that a parent, guardian, or person standing in loco parentis may initiate the temporary detention of a child eighteen years of age or younger in a mental health or mental retardation facility if the procedures and requirements of our opinion and order are fully complied with.

*Requirements for Commitment*

13. It is declared that all children eighteen years of age or younger who have been, are, or may be subject to admission or commission to a mental health or mental retardation facility in Pennsylvania are entitled to:

*Notice*

A. Prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the child's attorney must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the legislature establishes some other procedure consonant with our opinion and order, this notice must be sent not only to the child but also to the Clerk of the Court with jurisdiction to be forwarded to the child's attorney.

*Counsel*

B. Counsel during all significant stages of the commitment process and, if the child is indigent, appointment of free counsel.

*Presence of Child and Other Hearing Rights*

C. Presence of the child at all commitment hearings, an opportunity to be heard, confrontation

and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the child's behalf.

*Standard of Proof*

D. A finding by clear and convincing proof at the full commitment hearing that the child is in need of institutionalization.

*Probable Cause Hearing*

E. A hearing within seventy-two (72) hours from the date of the initial detention to test whether or not there is probable cause to believe that institutionalization is necessary.

*Full Commitment Hearing*

F. A full commitment hearing within two (2) weeks from the date of the initial detention.

*Waiver*

14. Excepting the rights to notice and counsel, any or all of the rights delineated in paragraph 13 may be waived by the child, and the neutral tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them. Because there may be situations where the child either does not understand his rights or is not competent to waive them, any or all of these rights, excepting notice and counsel, may also be waived by the child's attorney, and the neutral tribunal may accept the waiver upon a finding that the waiver is appropriate.



INJUNCTIVE RELIEF

15. It is ordered that the operation of section 402 (a) (2), section 402 (c), except for the language "any person voluntarily admitted shall be free to withdraw at any time," and section 403 (a) (2) of the Pennsylvania Mental Health and Mental Retardation Act (Act) is enjoined in that these sections of the Act are unconstitutional on their face and as applied under the due process clause of the Fourteenth Amendment to the United States Constitution. It is further ordered that the defendants and their officers, agents, servants, employees, successors, and those persons in active concert or participation with them are enjoined:

*Procedures*

A. To refrain from accepting or continuing the admission or commitment of any child eighteen years of age or younger under the Act to any mental health or mental retardation facility unless the child is or has been provided:

(1) Prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the child's attorney must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the legislature establishes some other procedure consonant with our opinion and order, this notice must be sent not only to the child but also to the Clerk of the Court with jurisdiction to be forwarded to the child's attorney.

(2) Counsel during all significant stages of the commitment process and, if the child is indigent, appointment of free counsel.

(3) Presence of the child at all commitment hearings, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the child's behalf.

(4) A finding by clear and convincing proof at the full commitment hearing that the child is in need of institutionalization.

(5) A hearing within seventy-two (72) hours from the date of the initial detention to test whether or not there is probable cause to believe that institutionalization is necessary.

(6) A full commitment hearing within two (2) weeks from the date of the initial detention.

Excepting the rights to notice and counsel, any or all of the rights delineated in paragraph 15(A) may be waived by the child, and the neutral tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them. Because there may be situations where the child either does not understand his rights or is not competent to waive them, any or all of these rights, excepting notice and counsel, may also be waived by the child's attorney, and the neutral tribunal may accept the waiver upon a finding that the waiver is appropriate.

*Regulations*

B. To promulgate and issue regulations and to publish them, within thirty (30) days as immediately effective, requiring that all mental health and mental retardation facilities in Pennsylvania (*see* 50 P.S. §4102 for the definition of "facility") adhere to the opinion and order in this action.



*Notice of Order*

C. To give notice forthwith to all state school and mental hospital directors and their delegates and all directors of all other mental health and mental retardation facilities in Pennsylvania of the opinion and order in this action. Further, to give notice forthwith to all judges of the Courts of Common Pleas in Pennsylvania of the opinion and order in this action.

*Access for Attorneys*

D. To provide to attorneys access to the grounds and facilities of all mental hospitals and institutions, to their individual clients, and to the institutional and hospital records pertaining to their clients' commitments.

*Procedures for Children Already Admitted or Committed*

E. To initiate procedures, commencing immediately, to assure that all children eighteen years of age or younger already admitted or committed pursuant to §§402 and 403 are either discharged or released or recommitted according to the procedures required by our opinion and order. Such discharge, release, or recommitment shall begin immediately and shall be concluded within one hundred and twenty (120) days of the date of this order, unless an extention is granted by this Court for good cause shown. Notation shall be made upon the medical records of such children that their discharge, release, or recommitment was effected pursuant to the opinion and order in this action. In addition, any person admitted or committed pursuant to §§402 or 403 at a time when he or she was eighteen years of age or younger but who has reached his or her nineteenth birthday shall be brought before a Commonwealth court or alternate neutral tribunal and in-

formed of his or her options under §§402 and 403 for voluntary withdrawal. Should such person choose to withdraw voluntarily, he or she shall be released immediately unless proper procedures are initiated pursuant to the appropriate Pennsylvania statutes governing the involuntary commitment of adults.

*Reports on Implementation*

F. To report to this Court within sixty (60) days and again within one hundred and fifty (150) days on the steps taken and progress made in the implementation of our opinion and order. The one hundred and fifty-day report shall describe, for each mental health or mental retardation facility, the number of children eighteen years of age or younger released, discharged or recommitted and the number of persons who have reached their nineteenth birthday but who were eighteen years of age or younger at the time they were admitted or committed pursuant to §402 or §403 who have been released, voluntarily admitted or committed, or involuntarily committed.

(s) John J. Gibbons
*C.J.*
(s) Daniel A. Huyett 3rd,
*D.J.*
(s) R. J. Broderick
*D.J.*



## NOTICE OF APPEAL

## IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

**Civil Action No. 72-2272**

Kevin Bartley; Steve Gentile; Leslie Levine; Vicki Mathews; Mark Weand; minors, through their next friend, individually and on behalf of all others similarly situated,
Plaintiffs

**v.**

Jack B. Kremens, individually and as Hospital Director of Haverford State Hospital; Helene Wohlgemuth, individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; William B. Beach, Jr., individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,
Defendants

## NOTICE OF APPEAL TO THE SUPREME COURT OF THE UNITED STATES

Notice is hereby given that Jack B. Kremens, et al., the Defendants above-named, hereby appeal to the Supreme Court of the United States from the final order

granting a permanent injunction in favor of Plaintiffs and against Defendants, entered in this action on November 17, 1975.

This appeal is taken pursuant to 28 U.S.C. §1253.

(s) Barry A. Roth
Barry A. Roth
*Assistant Attorney General*
*Counsel for Defendants*

---

[Caption Omitted]

AFFIDAVIT OF SERVICE

Barry A. Roth certifies that he, by certified mail, return receipt requested, served:

David Ferleger, Esq.
1427 Walnut Street
Philadelphia, Pa. 19102

John Gabroy, Esq.
1710 Spruce Street
Philadelphia, Pa. 19103

Thomas B. Harvey, Jr.
American Civil Liberties Foundation
260 South 15th Street
Philadelphia, Pa. 19102

Jay Stanley Pottinger
Assistant U. S. Attorney General
Department of Justice
Washington, D.C. 20530



Robert C. Burgdorf
National Association for Retarded Citizens
1235 North Eddy Street
South Bend, Indiana 46617

Peter Sandman
Youth Law Center of California
795 Turk Street
San Francisco, California 94102

by sending them a copy of the Notice of Appeal at the above address.

Barry A. Roth
Barry A. Roth
*Assistant Attorney General*

Dated:

Sworn to and subscribed before me on this 24th day of November, 1975.

(Illegible)
*Notary Public*

Supreme Court, U. S.
FILED
JUN 18 1976

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**APPENDIX**

# In the Supreme Court of the United States

**October Term, 1975**

**No. 75-1064**

JACK B. KREMENS, Individually and as Hospital Director of Haverford State Hospital; FRANK S. BEAL, Individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; WILLIAM B. BEACH, JR., Individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,

Appellants

v.

KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND; Minors, Through Their Next Friend, Individually and on Behalf of All Others Similarly Situated,

Appellees

*APPEAL FROM THE JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA*

**APPEAL DOCKETED JANUARY 27, 1976**
**JURISDICTION NOTED MARCH 22, 1976**

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IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

---

Civil Action No. 72-2272

---

Kevin Bartley; Steve Gentile; Lesile Levine; Vicki Mathews; Mark Weand, minors, through their next friend, individually and on behalf of all others similarly situated,
*Plaintiffs*

v.

Jack B. Kremens, individually and as Hospital Director of Haverford State Hospital; Helene Wohlgemuth, individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; William B. Beach, Jr., individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,
*Defendants*

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RELEVANT DOCKET ENTRIES

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1972

Nov. 16, Complaint filed.

Nov. 16, Plaintiffs' Memorandum of Law in support of Motion for Class Action and Convening of a Three-Judge Court filed.

Dec. [Illegible,] Defendants' motion to dismiss filed.

1973

Jan. 2, Plaintiffs' first set of interrogatories to Defendants filed.

March 13, Plaintiffs' Motion for class action filed.

June 8, Transcript of 5/10/73 filed.

Aug. 2, Defendants' Memoranda of Law in Support of Defendants' Motion To Dismiss and Defendants' Motion To Oppose Plaintiffs' Motion for a Class Action filed.

Oct. 4, Youth Law Center of San Francisco, California's request for leave to file brief amicus curiae and brief amicus curiae in support of plaintiffs on behalf of Youth Law Center filed.

Dec. 20, Second set of interrogatories to defendants filed.

1974

Jan. 25, Defendants' answers to second set of interrogatories filed.

April 2, ORDER [dated 4-1-74] that argument shall take place before a three-judge Court on 4-16-74 at 10:00 a.m. re: plaintiffs' motion for a class action determination and on defendants' motion to dismiss; briefs of the moving party shall be filed within 8 days from date of this Order, and reply briefs 5 days thereafter, etc. filed. 4-3-74 Entered and copies mailed.

April 16, Argued sur defendants' motions to dismiss, and for class action; Court stated that case may proceed as a single class action. [3-Judge]



April 19, ORDER that hearing and argument shall take place before the three-judge court at such time and place as the court shall designate following the filing of the final pre-hearing Order, by 5-1-74 for plaintiffs' final proposed order, and the holding of the final pre-hearing conference, scheduled for 5-28-74 at 11:00 a.m. in Room 3006, etc. filed. 4-22-74 Entered and copies mailed.

April 29, ORDER that Haverford State Hospital is dropped as a party defendant, and that complaint shall stand amended by said elimination; that this action shall be maintained as a class action under Rule 23(b) (1) and (2) of FRCP on behalf of the class comprised of all persons 18 years of age or younger who have been, are or may be admitted to mental health facilities in Pa. pursuant to 50 P.S. §§4402 and 4403, etc.; that David Ferleger, Esq. is appointed guardian ad litem for the plaintiffs and their class pursuant to FRCP Rule 17(c), etc. filed. 4-30-74 Entered and copies mailed.

April 30, ORDER that the Court Order of 4-19-74 [Paper #47] is amended filed. 5-1-74 Entered and copies mailed.

June 6, Answer filed.

July 29, Final Pre-Hearing Order, certificate of service filed.

July 30, Transcript of 4-16-74 re: argument on plaintiffs' motion for a class action determination and on defendants' motion to dismiss filed.

Aug. 21, ORDER granting petition of American Civil Liberties Foundation permitting same to participate

as *amicus curiae* in this cause filed. 8-23-74 Entered and copies mailed.

Aug. 21, ORDER that final hearing and argument shall take place on 9-9-74 at 10:00 a.m., and on 9-11-74 from 9:30 a.m.-1:00 p.m.; that pre-trial briefs are not required, but may be submitted by 9-3-74; that final pre-hearing Order is fully approved, etc. filed. 8-23-74 Entered and copies mailed.

Aug. 23, ORDER [dated 8-22-74] that Pennsylvania Association for Retarded Citizens [PARC], Inc. and National Center for Law and the Handicapped, Inc. are granted leave to participate as *amici curiae* herein filed. 8-26-74 Entered and copies mailed.

Sept. 3, Defendants' Brief, with exhibits in support thereof filed.

Sept. 6, Brief of Amici Curiae, Penna. Association for Retarded Citizens, Inc. and National Center for Law and the Handicapped, Inc. filed.

Sept. 16, Copy of Brief of Amici Curiae, Penna. Association for Retarded Citizens, Inc. and National Center for Law and the Handicapped, Inc. filed.

Sept. 16, Brief of American Civil Liberties Foundation of Pennsylvania, Inc., Amicus Curiae filed.

Sept. 30, Deposition of Dr. Joel S. Feiner, M.D. of 8-21-74 filed.

Oct. 2, Plaintiffs' Trial Brief, with certificate of service filed.

Oct. 7, Brief of *Amicus Curiae* United States of America, with certificate of service filed.



Oct. 7, Transcript of testimony of Evidentiary hearing of 9-9-74 filed.

Oct. 7, Transcript of testimony of Evidentiary hearing of 9-11-74 filed.

Oct. 7, Deposition of Dr. Barbara Armstrong of 3-2-73 filed. [Exhibit P-7]

Oct. 8, Order that Plaintiffs' proposed Findings of Fact and Conclusions of Law be filed on 10-21-74; Defendants' reply be filed within 10 days of receipt of plaintiffs' Proposed Findings of Fact and Conclusions of Law filed. 10-9-74 entered and copies mailed.

Oct. 18, Plaintiffs' proposed findings of fact and conclusions of law, certificate of service filed.

Oct. 30, Transcript of testimony of Evidentiary Hearing of 10-7-74, Third Day filed.

Nov. 1, Defendants' proposed findings of fact and conclusions of law, certificate of service filed.

Nov. 8, ARGUED SUR: Final merits of the case . . . C.A.V.

Nov. 8, ORDER that plaintiffs' request for admission of Exhibits 2 and 3 is DENIED filed. 11-11-74 Entered and copies mailed.

1975

June 25, Order denying plaintiffs' motion for temporary restraining order, etc. filed. 6/26/75 entered and copies mailed.

July 24, *Opinion*, Huyett, J., Gibbons, J. and Broderick, J. finding §§402 and 403 unconstitutional, etc. filed.

July 24, Order that judgment is entered in favor of plaintiffs and against defendants: Counsel for the parties shall confer and submit an appropriate form order consistent with Opinion within 20 days filed. 7/25/75 entered and copies mailed.

Aug. 7, DISSENTING OPINION, Broderick, J., to the opinion of the court of 7/24/75 filed. 8/7/75 entered and copies mailed.

Aug. 22, Defendants' notice of appeal filed. (Certificate of service) (75-2121)

Oct. 17, Defendants' exceptions to proposed order, etc. and certificate of service filed.

Oct. 31, Certified copy of Order from USCA wherein appellants' motion for leave to stay all proceedings until 30 days after the Supreme Court of the U. S. acts in this matter is GRANTED; motion by plaintiffs-appellees to dismiss appeal with memorandum of law in support of motion to dismiss appeal, etc. is DENIED without prejudice, etc. filed.

Nov. 17, ORDER that this action is properly maintained as a class action and that certain sections of the Pennsylvania Mental Health and Mental Retardation Act are declared invalid, etc. filed. 11-18-75 entered and copies mailed.

Nov. 25, Defendants' motion for a stay and certificate of service filed.

Nov. 26, Defendants' notice of appeal to the Supreme Court (Final Order) and certificate of service filed. (75-1064)

Dec. 1, ORDER that defendants' motion to stay is DENIED filed. 12-2-75 entered and copies mailed.



1976

Feb. 4, Certified copy received from the Supreme Court of the U. S. re file of petition for a writ of certiorari on 1-27-76 as #75-1064, etc. filed.

## COMPLAINT—NOVEMBER 16, 1972

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF
PENNSYLVANIA

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Kevin Bartley; Steve Gentile; Leslie Levine; Vicki Mathews; Mark Weand, minors, through their next friend, individually and on behalf of all others similarly situated,

Plaintiffs

v.

Haverford State Hospital; Jack B. Kremens, individually and as Hospital Director of Haverford State Hospital; Helene Wohlgemuth, individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; William B. Beach, Jr., individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,

Defendants

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## COMPLAINT—CLASS ACTION

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### I.

### PRELIMINARY STATEMENT

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1. Plaintiffs, individually and on behalf of all others similarly situated, seek declaratory and injunctive relief,



and damages, for violations of their civil rights resulting from the operation of certain parts of the Pennsylvania Mental Health and Mental Retardation Act of 1966 which permit the involuntary commitment of persons eighteen years of age or under to mental health facilities on a different basis than other persons and without notice, hearing, right to counsel and other procedural safeguards. The convening of a three judge court is also sought. The statutes are challenged on the grounds that they conflict with the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution.

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### II.

### JURISDICTION

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2. Jurisdiction is conferred upon this court by 28 U.S.C. § 1331 which provides for original federal question jurisdiction. The amount in controversy, exclusive of interest and costs, is greater than $10,000.

3. Jurisdiction is conferred upon this court by 28 U.S.C. § 1343(3) which provides for original jurisdiction in all suits authorized by 42 U.S.C. § 1983 to redress the deprivation under color of state law of any right, privilege or immunity secured by the Constitution of the United States and by federal law. Defendants here act under color of law.

4. Plaintiffs' action for declaratory and injunctive relief, and for damages, is authorized by:

a. 28 U.S.C. 2201, 2202, 2281 and 2284, and by Rules 57 and 65 of the Federal Rules of Civil Pro-

cedure, which relate to declaratory judgments, injunctions and three judge courts.

b. 42 U.S.C. §§ 1983 and 1988, which relate to civil rights actions.

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## III.

## THREE-JUDGE COURT

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5. This is a proper case for determination by a three-judge court pursuant to 28 U.S.C. §§ 2281 and 2284 since Plaintiffs seek an injunction to restrain Defendants, a state institution and state officers, from the enforcement, execution and operation of portions of state statutes (50 P.S. §§ 4402(a)(1), 4402(a)(2), 4402(c), 4403(a)(1), 4403(a)(2) and 4403(c)) of state-wide applicability on the ground that said statutes are contrary to the United States Constitution.

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## IV.

## CLASS ACTION

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6. The named Plaintiffs bring this action on their own behalf and, pursuant to Rule 23(a), 23(b)(2) of the Federal Rules of Civil Procedure, on behalf of all others similarly situated.

7. The members of the class of Plaintiffs similarly situated are all persons under eighteen years of age who have been, are, or may be admitted or committed to Haverford State Hospital and all other state mental health facilities under the challenged provisions of the state statute.



8. The requirements of Rule 23 are met in that: the class is so numerous that joinder of all members is impractical (and the total membership of the class is indeterminate); there are questions of law and fact common to the class; the claims of the representative parties are typical of the claims of the class; the representative parties will fairly and adequately protect the interests of the class; and the parties opposing the class have acted on grounds generally applicable to the class, thereby making appropriate final injunctive and declaratory relief with respect to the class as a whole.

9. Defendant Jack B. Kremens, Hospital Director of Defendant Haverford State Hospital, is sued as representative of the directors of all mental health facilities in Pennsylvania, all of which are under the authority and supersion and regulation of Defendants Wohlgemuth and Beach. All the allegations in Paragraph 8 above (with the exception of the last clause) are applicable here and are incorporated by reference.

10. The questions of law and fact involved are:

a. Are the representative parties, and their class, admitted or committed involuntarily to Defendant Haverford State Hospital and other mental health facilities pursuant to the challenged statutory provisions?

b. Do Defendants operate, execute and enforce the challenged statutes?

c. Are the challenged statutes contrary to the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution?

## V.

## PLAINTIFFS

11. Plaintiff Kevin Bartley is a citizen of Pennsylvania, age 16, having been born November 4, 1956.

12. Plaintiff Steve Gentile is a citizen of Pennsylvania, age 18, having been born March 20, 1954.

13. Plaintiff Leslie Levine is a citizen of Pennsylvania, age 15, having been born October 8, 1957.

14. Plaintiff Vicki Mathews is a citizen of Pennsylvania, age 15, having been born September 10, 1957.

15. Plaintiff Mark Weand is a citizen of Pennsylvania, age 15, having been born June 13, 1957.

16. All named Plaintiffs are being held at Defendant Haverford State Hospital against their will having been admitted or committed by Defendants or under their direction pursuant to the challenged sections of the Pennsylvania Mental Health and Mental Retardation Act of 1966. Such admissions and commitments were accomplished without notice, hearing, right to counsel or order of court.

## VI.

## DEFENDANTS

17. Defendant Haverford State Hospital is a mental health "facility" under Section 102 of the Pennsylvania Mental Health and Mental Retardation Act of 1966.



It receives admissions and commitments of persons, including Plaintiffs and their class, under said act.

18. Defendant Jack B. Kremens is Hospital Director of Defendant Haverford State Hospital and is charged with supervision and administration of the facility. See Sections 102 and 203 of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (hereafter the "Act"). It is to Kremens or his delegate that applications for admission, commitment and release must be made. See Sections 402 (b), 403 (b) and 403 (c) of the Act.

19. Defendant Helene Wohlgemuth is the Secretary of Public Welfare of the Commonwealth of Pennsylvania which department has the power and duty to enforce the Act and all regulations necessary and appropriate to the proper accomplishment of the Act and to operate and assign functions to all state facilities. See Sections 201 (2) and 202 (a) of the Act.

20. Defendant William B. Beach, Jr. is the Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania. He has general authority to supervise and regulate mental health facilities within Pennsylvania.

## VII.

## FACTUAL ALLEGATIONS

*Kevin Bartley*

21. Plaintiff Kevin Bartley was committed to Haverford State Hospital on November 30, 1971 under Section 403 (a) (2) of the Act.

22. He was committed by his mother although he did not wish to enter the hospital then and does not wish to remain now. Kevin Bartley is critical of many of what he believes are the hospital's shortcomings: e.g., arbitrary regulations, the staff's playing favorites with patients, unnecessary punishments for minor rule infractions, and transfer to locked wards as punishment for mere allegations of wrongdoing, without hearing or proof.

23. Bartley believes that nothing worthwhile is occurring to him inside the hospital and that his time is mostly being wasted. This is true. When he obtains release, he plans to go to school and learn a usable trade.

*Steve Gentile*

24. Plaintiff Steve Gentile was committed to Haverford State Hospital on August 24, 1971 by his father under Section 403 (a) (2) of the Act.

25. Gentile entered the hospital involuntarily, is being detained there involuntarily and wishes to leave but is restrained from doing so by Defendants and the operation of the challenged portions of the Act.

*Leslie Levine*

26. Plaintiff Leslie Levine's mother committed her to Haverford State Hospital on October 11, 1972 under Section 403 (a) (2) of the Act.

27. Levine does not wish to remain at the hospital but is restrained from leaving by Defendants and by the operation of the challenged portions of the Act.

28. Levine was committed to the hospital because she does not get along with her mother and sister. Her



parents are divorced; her father is remarried and living in Florida. Leslie Levine would like to be with her father; they get along well and, every time she spends some time with him, her behavior is excellent. However, because she is with her mother and sister and does not get along with them, Levine is an involuntary mental hospital patient.

*Vicki Mathews*

29. Plaintiff Vicki Mathews was committed to Haverford State Hospital on August 9, 1972 by her parents under Section 403 (a) (2) of the Act.

30. She entered the hospital involuntarily.

31. Mathews does not get along well with her parents and has in the past run away from home. If she were considered a "delinquent," and dealt with through the juvenile court process, she could not be institutionalized against her will except after a full hearing, upon order of a court. In fact, as the mental health commitment laws permit, her parents had the choice of avoiding the due process protections afforded juveniles in other contexts and of dealing with her in their own way, thus depriving Mathews of any hearing and committing her to a mental hospital.

32. Because her parents had the financial means, on information and belief, they applied for her discharge from the hospital under Section 403 (c) so that she could be shipped, against her will, to a boarding school in Texas.

*Mark Weand*

33. Plaintiff Mark Weand was admitted to Haverford State Hospital on June 23, 1972 by his mother under Section 402 (a) (2) of the Act.

34. After another hospital would not admit him because of his age, Weand first entered Haverford for medical reasons because of excess use of drugs. Once at the hospital, his mother was convinced by agents and employees of Defendants to have Weand admitted for psychiatric reasons. Weand did not wish to become a mental patient and repeatedly has informed Defendants' agents and employees of his desire to leave. They have not permitted him to do so.

35. At the hospital, Weand has not been involved with any therapeutic drug programs because he has not been addicted to any drugs.

36. His mother is concerned about him but will not apply for his release except upon the approval of the hospital physicians, employees and agents of Defendants. If Weand were a voluntary patient under Section 402 of the Act and were over eighteen, he would be permitted to leave the hospital "at any time" regardless of the physicians' approval or opinion.

37. The major reason Weand has been hospitalized for the past five months is that the hospital's agents and employees have considered his attitude hostile and aggressive. The basis for this "hostile" and "aggressive" attitude is Weand's belief that he doesn't belong in the mental hospital and Weand's questioning and criticism of the hospital regimen and his treatment there.

*The Statutory Scheme*

38. Section 402 of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (50 P.S. § 4402) provides as follows: (Those parts which are challenged



as unconstitutional by this Complaint are emphasized by underlining [italics])

Section 402. Voluntary Admission; Application, Examination and Acceptance; Duration of Admission.

(a) Application for voluntary admission to a facility for examination, treatment and care may be made by:

(1) Any person *over eighteen years of age.*

(2) *A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.*

(b) When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he may be admitted.

(c) *Except where application for admission has been made under the provisions of Section 402 (a) (2) and the person admitted is still eighteen years of age or younger,* any person voluntarily admitted shall be free to withdraw at any time. *Where application has been made under the provisions of Section 402 (a) (2), only the applicant or his successor shall be free to withdraw the admitted person so long as the admitted person is eighteen years of age or younger.*

(d) Omitted here.

39. Section 403 of the Act (50 P.S. § 4403) provides as follows: (Those parts which are challenged as unconstitutional by this Complaint are emphasized by underlining [italics])

Section 403. Voluntary Commitment; Application, Examination and Acceptance; Duration of Commitment.

(a) Application for voluntary commitment to a facility for examination, treatment and care may be made by:

(1) Any person *over eighteen years of age.*

(2) *A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.*

(b) The application shall be in writing, signed by the applicant in the presence of at least one witness. When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he shall be committed for a period not to exceed thirty days. Successive applications for continued voluntary commitment may be made for successive periods not to exceed thirty days each, so long as care or observation is necessary.

(c) No person voluntarily committed shall be detained for more than ten days after he has given written notice to the director of his intention or desire to leave the facility, *or after the applicant or his successor has given notice of intention or desire to remove the detained person.*

(d) Omitted here.

40. The only other provisions for civil commitment to a mental health facility provided by the Act are:



a. Section 404 which permitted commitment of persons upon application of third parties (including parents, guardians, individuals standing in loco parentis, etc.) upon application with certificates of two physicians. Because of its denial of Constitutional Due Process rights, this section has been declared unconstitutional. See Section 404 and *Dixon v. Attorney General of the Commonwealth of Pennsylvania,* 325 F. Supp. 966 (M.D. Pa. 1971).

b. Section 405 permits involuntary detention of persons, regardless of age, under emergency conditions for no longer than ten days.

c. Section 406 permits involuntary commitment of persons, regardless of age, upon petition to the state court of common pleas, and after hearing and examination. The respondent to such petition has the right to notice of the hearing, the right to counsel and the opportunity and right to present testimony and evidence in his or her behalf and to confront his or her accusers. The court may order outpatient or partial hospitalization instead of in-hospital commitment.

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## VIII.

## FIRST CAUSE OF ACTION

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For a First Cause of Action, Plaintiffs reallege Paragraphs 1 through 40 above, which are incorporated herein by reference, and further allege:

41. Voluntary patients over eighteen years of age enter facilities under the Act on their own application and

volition under Section 402 or 403 and may leave and discharge themselves either at any time (Section 402) or upon proper written notice (Section 403). Plaintiffs and their class are denied such entrance and separation from the facility by the challenged portions of these sections of the Act.

42. The statute thus creates two classes of potential and actual "voluntary" admittees, distinguishable only on the basis of age. There is no adequate state justification for this arbitrary classification.

43. A person over eighteen years of age who does not wish to enter a facility may be placed there involuntarily only upon the order of a court pursuant to the procedures, including a petition, notice and hearing, mandated by Section 406 of the Act. A person under eighteen years of age who does not wish to enter a facility may be placed there involuntarily simply upon the application of a parent, guardian or individual standing in loco parentis; no notice or petition is required nor is any sort of hearing or court order provided for.

44. The statute thus creates two classes of potential and actual involuntary admittees and committees, distinguishable only on the basis of age. There is no adequate state justification for this arbitrary classification.

45. The challenged portions of the Act and Defendants' actions in operating, enforcing and executing the same, deny Plaintiffs and their class the equal protection of the laws in violation of the Fourteenth Amendment to the United States Constitution.



## IX.

## SECOND CAUSE OF ACTION

For a Second Cause of Action, Plaintiffs reallege Paragraphs 1 through 40 above, which are incorporated herein by reference and further allege:

46. By operation of the challenged portions of the Act, Plaintiffs and their class are detained and incarcerated involuntarily in mental hospitals and other facilities without:

a. the right to notice;

b. the right to a hearing;

c. the right to counsel and, if indigent, appointment of counsel;

d. the right to present evidence and testimony on their own behalf;

e. the right to subpoena witnesses and documents;

f. the right to confront and cross-examine witnesses against them and those who wish them to enter a facility;

g. the right to independent expert examination and assistance;

h. the right to be involuntarily detained only upon decision of a disinterested and impartial decision-maker;

i. the right to be involuntarily detained only upon a decision that they are in need of care, treatment or observation, such decision being based on clear and convincing evidence;

j. the right to appeal and review, including provision for assistance of counsel and record and transcript without cost if appellant is unable to pay the cost thereof;

k. other procedural safeguards.

47. By operation of the challenged portions of the Act, and by Defendants' actions in operating, enforcing and executing the same, Plaintiffs and their class are deprived of their life, liberty and property without due process of law in violation of the Fourteenth Amendment to the United States Constitution.

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## X.

## PRAYER FOR RELIEF

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WHEREFORE, Plaintiffs respectfully pray, on behalf of themselves and all others similarly situated, that this Honorable Court:

1. Assume jurisdiction of this cause, convene a three-judge court pursuant to 28 U.S.C. §§ 2281 and 2284 to determine this controversy, and set this case promptly for an expedited hearing;

2. Determine by Order, pursuant to Rule 23 (c) (1) of the Federal Rules of Civil Procedure, that this action be maintained as a class action;

3. Enter a final judgment, pursuant to 28 U.S.C. §§ 2201 and 2202 and Rule 57 of the Federal Rules of Civil Procedure declaring that the challenged portions of the Pennsylvania Mental Health and Mental Retardation Act of 1966, that is 50 P.S. §§ 4402 (a) (1), 4402 (a) (2),



4402 (c), 4403 (a) (1), 4403 (a) (2), and 4403 (c) (see paragraphs 38 and 39 above), are invalid, void and of no effect on the grounds that they violate the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution;

4. Enter preliminary and permanent injunctions enjoining Defendants from enforcing and executing such statutory provisions;

5. Award damages to each of the named Plaintiffs in the amount of $15,000 each for unconstitutional deprivation of their rights;

6. Allow Plaintiffs their costs herein and reasonable attorney's fees;

7. Grant such additional and alternative relief as may be deemed by this Court appropriate, just, proper and equitable.

Respectfully submitted,

(s) David Ferleger
David Ferleger
*Attorney and Next Friend for Plaintiffs*
Mental Patient Civil Liberties Project
121 South 18th Street
Philadelphia, Pa. 19103
(215) 561-4715

On the Brief:

Ronald Soskin
Stan Abramson

Dated November 16, 1972

## MOTION TO DISMISS

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

[Title omitted in printing.]

## MOTION TO DISMISS

Defendants move that this Honorable Court dismiss the above captioned action on the basis that Plaintiffs have failed to plead an action upon which relief may be granted.

Marx S. Leopold
*Assistant Attorney General*

December 12, 1972



IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted]

## FIRST SET OF INTERROGATORIES TO DEFENDANTS

*Definitions*

As used in the interrogatories below, the following words shall be taken to have the following meanings:

a. "Juvenile (s)"—Persons eighteen years of age or younger.

b. "Facility (ies)"—"Any mental health establishment, hospital, clinic, institution, center, day care center or other organizational unit, or part thereof, which is devoted primarily to the diagnosis, treatment, care, rehabilitation or detention of mentally disabled persons." (As defined in the Mental Health and Mental Retardation Act of 1966).

c. "Act"—The Pennsylvania Mental Health and Mental Retardation Act of 1966.

d. "Director (s)"—"The administrative head of a facility and includes superintendents." (As defined in the Act).

e. "Department"—The Department of Public Welfare.

f. "Adult (s)"—Persons over eighteen years of age.

g. "Civil Commitment"—Commitment to a facility under Section 406 of the Act.

h. "Voluntary Admission"—Admission or commitment to a facility under Section 402 or Section 403 of the Act.

i. "State"—Pennsylvania, often with reference to the state government.

*Interrogatories*

1. Name all the state facilities, that is, those owned and operated by the state. Also, their addresses.

2. What are the names of all the facilities in Pennsylvania which are privately owned, regulated by the state and the Department, and which admit or commit any persons under the Act? Also, their addresses?

3. What are the policies of the Department with regard to criteria for admission or commitment of juveniles to facilities, that is, what criteria are used?

4. What are the policies of the Department with regard to criteria for admission and commitment of adults to facilities, that is, what criteria are used?

5. What are the policies of Directors with regard to acting upon applications for voluntary admissions of juveniles to facilities, that is, what criteria are used?

6. What are the policies of Directors with regard to acting upon applications for voluntary admissions of adults to facilities, that is, what criteria are used?

7. Identify and describe the nature, custody and location of all memoranda, directives, orders, policies, regulations and other or similar documents issued by the Department or other state authorities or known to Defendants which pertain to the voluntary admission or civil commitment of juveniles to facilities.



8. Identify and describe the nature, custody and location of all memoranda, directives, orders, policies, regulations and other or similar documents issued by the Department or other state authorities or known to Defendants which pertain to voluntary admission or civil commitment of adults to facilities.

9. Name all juveniles presently in all facilities as voluntary admissions and provide the name of the facility each is in.

10. Name all juveniles presently in all facilities as civil commitments and provide the name of the facility each is in.

11. For each juvenile in a facility as a voluntary admission, what is or are the major behaviors or activities upon which such admission was based?

12. For each juvenile in a facility as a civil commitment, what is or are the major behaviors or activities upon which such commitment was based?

13. For each juvenile in a facility as a voluntary admission, what is the name and address of the applicant for admission and identify the relationship of the applicant to the juvenile (e.g., parent, guardian or person *in loco parentis*) ?

14. For each juvenile in a facility as a result of a civil commitment, what is the name and address of the

Petitioner and identify the relationship of the Petitioner to the juvenile?

(s) David Ferleger
David Ferleger
*Mental Patient Civil Liberties Project*
121 S. 18th Street
Philadelphia, Pa. 19103
*Attorney for Plaintiffs*

December 22, 1972

Please answer, in accordance with Rule 33, within thirty days.



IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

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Civil Action No. 72-2272

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[Title omitted in printing.]

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## MOTION FOR CLASS ACTION

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Plaintiffs, by their attorney and next friend, David Ferleger, Esquire, respectfully move this Honorable Court to order that this action be maintained as a class action.

Rule 23(c) provides:

> As soon as practicable after the commencement of an action brought as a class action, the court shall determine by order whether it is to be so maintained. An order under this subdivision may be conditional, and may be altered or amended before the decision on the merits.

In their *Memorandum of Law in Support of Motion for Class Action and Three-Judge Court,* filed with the Complaint, Plaintiffs detailed the argument on which they here rely at pages 1 through 3 of that memorandum. No

memorandum or motion has been filed in opposition by Defendants, except a motion to dismiss under Rule 12 (b) (6).

Respectfully submitted,
(s) David Ferleger
David Ferleger, Esquire
Mental Patient Civil Liberties Project
121 South 18th Street
Philadelphia, Pa. 19103
*Attorney and Next Friend to Plaintiffs*

March 13, 1973

[Certificate of Service omitted.]



ORDER

[Caption Omitted]

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AND NOW, this 25 day of April, 1973, it is hereby ordered and decreed that:

1. The two affidavits of juveniles at Haverford State Hospital submitted by Plaintiffs on April 12, 1973 to this Court be sealed and impounded until further order of this Court;

2. The parties and their attorneys shall not disclose to others the names of the affiants except with the permission of the Court. The contents, without identifying data, may be disclosed;

3. Defendants, their agents and employees, are enjoined from interfering with the First Amendment rights of affiants and from punishing, disciplining, interrogating or otherwise imposing sanctions on affiants by reason of their affidavits herein.

For the Court:
(s) Thomas A. [Illegible]
*J.*

[Caption Omitted]

## MOTION FOR SEALING OF AFFIDAVITS AND PROTECTION OF AFFIANTS

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David Ferleger, attorney for Plaintiffs, respectfully represents that:

1. Attached are two affidavits of juveniles now at Haverford State Hospital pursuant to the challenged portions of the state mental health act. Their parents and various mental health professionals, including the Defendants and their agents, caused their commitment.

2. The affiants would be embarassed and their (and their families') reputation affected adversely by public disclosure of their names and their affidavits.

3. The affiants fear that the Defendants and their employees will take disciplinary or other action against them for their criticisms of their confinement as expressed in these affidavits.

Wherefore, it is respectfully prayed that: 1) these affidavits be sealed and impounded until further order of the Court; 2) the parties and their attorneys be ordered not to disclose the names of the affiants to the public except with the permission of the Court; and 3) the Defendants, their agents and employees be enjoined from interfering with the First Amendment rights of affiants and from punishing, disciplining, interrogating or otherwise imposing sanctions on affiants by reason of their affidavits herein.



Respectfully submitted,
(s) David Ferleger

David Ferleger, Esquire
*Mental Patient Civil Liberties Project*
121 S. 18th Street
Philadelphia, Pa. 19103

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This is to certify that on day of April, 1973, I mailed a copy of the foregoing to Marx Leopold, Esq. and Barry Roth, Esq., Office of Legal Counsel, Department of Public Welfare, Harrisburg, Pa.

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David Ferleger

[Caption Omitted]

AFFIDAVIT

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My name is A . . . M . . . I was transferred to Haverford from the University of Pennsylvania Hospital. My parents brought me here, but I didn't want to come. It was too late, I couldn't do anything about it. I said I didn't want to stay here. The doctor got me to admit that I needed help but I told him that I still didn't want to stay. Like I know some girl that was here a couple of weeks ago, Debbie Geiger, her parents told her they were going to see a doctor—that's how she got here. But if you're under 18, well you know.

When I first got here they pushed me into a room and told me to take off my clothes and put on pajamas. Then they took me up to the fifth floor. I wasn't expecting to be locked up. It really drives you crazy. They didn't explain anything to me—they put you up there and that's it. My mother says if she knew that she wouldn't have put me in here. I was up there 3 or 4 days before I was sent to Building 9.

They threaten you here—that's the really bad part. You do what we say or you go up the hill or something—restrictions. Like me and D . . . D . . .—we'll probably get sent up the hill again cause we didn't go to our half hour of art therapy. D . . . got sent up for five days because he wouldn't take his restrictions. They don't care—they don't care about anything. The evening and late night staff stinks. The only staff that really cares is the day staff.



I got transferred to Building 4 one night. I cut myself on purpose. My hands were bleeding and they said I was going for a tetanus shot. They didn't explain what they were doing or tell you they were taking you up. They should at least have told my parents. I would still be there but my doctor, Dr. Kratsa, got me back the next day. If you get sent up on a Friday and your doctor is only here Tuesday, Wednesday and Thursday, you'll be there till next Tuesday at least. Do you think you can do anything about the restrictions and us getting sent up the hill?

I am presently a patient at Haverford State Hospital. Since a notary public is not available at the hospital and since I am not able to secure release for the purpose of signing before a notary public, I am forced to sign without notarization. I swear that the above statements are true and correct to the best of my knowledge, information and belief and I sign below under pain of perjury.

(s) A . . . M . . .

Signed on this 9th day of April, 1973.

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[Caption Omitted]

AFFIDAVIT

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My name is D . . . D . . . I am 14 years old and live with my parents at 2624 Sunset Boulevard in Broomall, Pennsylvania.

Before I got here I was on probation for truancy. I broke probation because I was truant again. My parents told me they wanted to have a meeting with me down at Haverford State. My mom said a psychiatrist and a social

worker would be there. This woman at the Media Court House recommended to my parents that they bring me here. They wanted me to come that day but I said no, I wanted to say goodbye to my friends that night. I came the next morning at 7 a.m. I didn't even get to see my probation officer. When I got to the hospital the doctor, Dr. Kratsa, wanted me to go to reform school. My parents kept saying no. They made it sound like if I didn't come here I'd be going to reform school. So I figured it would be a lot better here than reform school. So I said yes. That's how they tricked me.

About the only big complaint I have is the restrictions. That's the only thing that's a matter with this hospital. I was supposed to sit in my alcove for two nights because I didn't do clean-up. I got sent up the hill to the locked building because I wouldn't take my restrictions. I think that's pretty stupid. Why should we be sent up there? We don't belong there with those people. They ought to have a better way of punishing you. I was there for 5 days—I've never been locked up for a length of time like that before. There are people there that bothered me and wanted me to let them do stuff to me, but I don't want to get them in trouble—that's just part of their problem. One guy used to wake me up and pounce on top of me and hit me.

The fourth floor of Building 4 is worse than the fifth floor where I got sent the first time. I had a bad day in Building 9 and I was mixed up and I didn't want to stay there that night, but they wouldn't let me go to Building 4 just for the night. So I broke a window to get sent there. They found phenobarbitol tablets in my room after I broke the window. I got them here at the hospital—a lot of kids in the building did. That's why a lot of us got sent



up here. I had a bowl of grass too that I had from home. My friends used to bring up stuff too. The fourth floor is worse than the fifth. I've been here over a week now. Most of them on this floor want to try stuff with me but I won't let them. One guy gave me all sorts of presents and then he told me what he wanted me to let him do just like the others, but I told him no. I want to get off this floor. I'll never bring any dope in anymore. I like the stuff they're giving me here though—I'm flying. Don't let them change it. I'd rather be on the fifth floor again or in Building 9. I want to be able to go home on the weekends. I'll write a commitment saying I won't do dope anymore. I'd like you to try and help me. I want you to talk to my doctor, Dr. Kratsa, about all of this.

I am presently a patient at Haverford State Hospital. Since a notary public is not available at the hospital and since I am not able to secure release for the purpose of signing before a notary public, I am forced to sign without notarization. I swear that the above statements are true and correct to the best of my knowledge, information and belief and I sign below under pain of perjury.

(s) D . . . D . . .

Signed on this 9th day of April, 1973.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

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Civil Action No. 72-2272

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Kevin Bartley, Steve Gentile, Leslie Levine, Vicki Mathews, Mark Weand, minors, through their next friend, individually, and on behalf of all others similarly situated

vs.

Haverford State Hospital, Jack B. Kremens, et al.

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Oral examination before trial by Dr. Barbara Armstrong, at the law office of Mental Patient Civil Liberties Project, David Ferleger, Esquire, 121 South 18th Street, Philadelphia, Pennsylvania, on Friday, March 2, 1973, at 10:00 a.m., before Patricia M. Kosmalski, Approved Reporter.

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Present:

David Ferleger, Esq., and Stan Abramson, Esq., Counsel for the Plaintiffs.

Barry A. Roth, Esq., Assistant Attorney General, Counsel for the Defendants.

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(2) (It is stipulated and agreed by and between counsel that sealing, filing, and certification of the



examination before trial be waived, and that all objections, except as to the form of the questions, be reserved to the trial of the cause.)

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DR. BARBARA ARMSTRONG, Director of Adolescent Services, Haverford State Hospital, Haverford, Pennsylvania, sworn.

MR. FERLEGER: Dr. Armstrong, do you understand the purpose of this deposition?

THE WITNESS: No.

MR. FERLEGER: The purpose of a deposition, under the Federal Rules of Civil Procedure, under the rules of lawsuits conducted, each side is afforded the opportunity for discovery to find out what potential witnesses may have to say, and to record testimony in case it is needed in the future for court. The deposition can be used in court to contradict or impeach what you say. It can be used in court if it happens that at the time of trial or hearing, you happen to (3) be more than a hundred miles away.

For example, you can't come if you should die before the court hearing. This deposition can be used as your testimony in that case, and under other exceptions and circumstances, it can also be used.

Because it can be used in court and because of the seriousness of the discovery process, you were sworn at the time this deposition was taken. So, you are obliged to tell the truth, as this is a serious kind of thing we are about to begin here today.

THE WITNESS: Yes. I understand.

MR. FERLEGER: Have you read the complaint and memorandum in the Bartley suit?

Mr. Roth, I would appreciate it if you don't shake your head and answer for her.

MR. ROTH: I am not answering.

THE WITNESS: I am not sure. I remember I read the deposition, I guess, in this case, of Dr. Kremens.

MR. FERLEGER: Have you read this paper captioned, "Complaint in Class, More Than In Law, of Class Action"?

(4) MR. ROTH: Do you mind showing me copies? Do you want to state your purpose of this deposition—I imagine, your objective, instead of going into needless impressions or embarrassment?

MR. FERLEGER: My objective is to determine what information Dr. Armstrong might have that would lead to discovery of other relevant material in this lawsuit. Since she is the doctor of a number of named plaintiffs and other members of this class action, I want to talk to her about problems involved. I don't know where you got the idea I have the desire to embarrass or press her.

MR. ROTH: I am concerned that this is going to be a fishing deposition, and I am going to make a motion to discontinue the deposition.

MR. FERLEGER: As to what questions I ask, if you want to object, you can object.

MR. ROTH: I am well aware of the rules of federal court.



I want you to know that I will make the appropriate motion now to terminate this deposition.

MR. FERLEGER: Any motion you wish to (5) make is up to you.

MR. ROTH: Let's proceed. Let's get on to the deposition proper.

THE WITNESS: Mr. Ferleger, what is the proper procedure? If you don't mind, may I ask you a question?

MR. FERLEGER: No, I will be glad to answer any questions you have, if I can.

THE WITNESS: Is it necessary that I have read the memorandum, which I did not see? I have no idea of its contents.

MR. FERLEGER: It is necessary. I was going to try to find out as to whether you were familiar—

THE WITNESS: My capacity is, in addition to being an administrator, as well as a director, a director of a specific specialty service named, "Adolescent Services," at Haverford State Hospital. I am not just one of the hospital's doctors involved in certain cases. Therefore, I must represent my staff.

Secondly, I would like to request that any correspondence or memorandums that were sent to or by Dr. Kremens in regard to this suit, I (6) be allowed to see.

MR. FERLEGER: Certainly. I think the appropriate thing for you to do is to ask your counsel to share with you the legal papers that were filed with the court.

MR. ABRAMSON: I want to mention that at any time if you don't understand or realize what it is we are asking you, or you are not quite clear on it, feel free to ask a question. Don't hesitate because you don't understand what you are being asked. Then again, please do not answer any question until you do understand it.

MR. FERLEGER: In reference to what you just said, doctor, we have asked you to come to this deposition, and what you say here the law requires it be your opinion and your feelings, not the feelings of your staff or Dr. Kremens.

If we had wanted the hospital's position—or personnel—at Haverford State Hospital, we would have asked them to send, under federal rules, a representative of the hospital.

We ask you, Dr. Barbara Armstrong, because you took an oath, to say what your answers are (7) to these questions.

THE WITNESS: That I understand, but there is a condition, in that you ask for, also, at least, a licensed representative presently in the hospital. In that regard, I have to convey information I haven't gathered myself.

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*Direct Examination*

BY MR. FERLEGER:

Q. Can you give us your background, education, and professional experience?

MR. ROTH: If we can dispense with that, or do you plan to attack her credibility as a psychiatrist



or as a licensed psychiatrist who practices at Haverford State Hospital? It would save time.

MR. FERLEGER: She might have more qualifications.

MR. ROTH: Can you indicate the purpose of it?

MR. FERLEGER: Her experience and educational background is certainly relevant in court and—

MR. ROTH: The only way it is relevant (8) is if you are going to attack her credibility as a practicing psychiatrist.

MR. FERLEGER: If I want to qualify her as an expert witness, it is relevant.

MR. ROTH: But the question is whether we can agree she is an expert witness. Do you want her to perform as an expert witness?

MR. FERLEGER: This is discovery.

MR. ROTH: You are fishing.

MR. FERLEGER: I am not fishing.

BY MR. FERLEGER:

Q. (Continued) Where did you go to school?

A. To Temple undergraduate school and Hahnemann Medical College, and the University of Pennsylvania Hospital for Psychiatric Residence, with a specialty in psychiatry.

Q. Did you go from the University of Pennsylvania Hospital to Haverford?

A. No, I was at Devereux for a year, and for three years I was chairman of the Department of Psychiatry for

a U.S. Army hospital in Badcreusnach, Germany, and upon returning to the United States, I took a position at Haverford State, with the purpose of setting up and directing an adolescent service.

(9) Q. Did your work involve adults and adolescents?

A. Child guidance clinic and in an adolescent clinic. So my work did involve both adults and children as chairman of that department.

Q. How long have you been at Haverford?

A. Four years.

Q. How long have you been the Director of Adolescent Services?

A. The entire time.

Q. During these past four years, have you had experience with the court commitments of juveniles, as well as voluntary commitments?

A. Yes, I have.

Q. Have you testified in court hearings?

A. Yes.

Q. For juveniles?

A. Yes.

Q. Have you also been involved in procedures for admission of juveniles, pursuant to application by their parents under the Act?

A. Yes.

Q. Can you tell me, please, what the procedure is at Haverford when parents call up or present themselves or their children at the hospital, saying they want the (10) child to be admitted as a voluntary patient?

A. The hospital has no specific admission policy. It follows the Mental Health and Retardation Act of 1966.

You are familiar with the Act?



Q. I didn't mean the criteria. I am just interested in what happens—

MR. ROTH: I object. I think Dr. Armstrong answered that question. You asked her what procedure occurs at Haverford, and she stated it is in compliance with the Mental Health and Retardation Act.

BY MR. FERLEGER:

Q. The Act says the director makes a finding, but Jack Kremens doesn't do that.

MR. ROTH: I object to this questioning. You asked her what the procedure is and she has informed you.

MR. FERLEGER: Your objection is noted. She can now answer.

MR. ABRAMSON: What we are interested in is not what the Act calls for specifically, but how it is applied at the hospital. In other words, if, for instance, a parent or guardian (11) feels that they would like to have their child, or the person who they are responsible for, enter the hospital, what are your actual mechanics: who do they see; what actually goes on or takes place before the child is or is not admitted, in a very practical sense?

MR. ROTH: I appreciate this elaboration, Mr. Abramson.

We are confining this to 402 and 403 of the Act?

MR. ABRAMSON: Yes.

THE WITNESS: Also, persons 18 years of age and under?

MR. ABRAMSON: Yes.

A. Practically speaking, my understanding of the Mental Health and Retardation Act is such that the director may designate a professional on his staff to make an examination. Subsequently, what happens, this prevents a person, the applicant who is either a parent or guardian, from acting in loco parentis.

The child who is 402, is then brought in for examination. On a 402, it is a prescheduled general admission, therefore, they are examined by one of the members of the Adolescent Services, at which time, a (12) determination is made whether the child needs, in fact, care in the hospital, or what facilities. If it is not indicated, the child is not admitted. If it is indicated, a child is admitted and sent to the appropriate facility. As part of our services, if the child needs the services of the Adolescent Services, then he is admitted to the hospital at large. A social worker, in fact, who is designated as part of the Adolescent Services, then contacts the parent for further personal history or further studies.

Q. Is that initial examination by one of your staff?
A. Generally.
Q. Does that take one day or half a day?

MR. ROTH: I object to that question.

BY MR. FERLEGER:
Q. (Continued) How long?

MR. ROTH: I object to that question.

MR. FERLEGER: She can answer now.



MR. ROTH: I am familiar. I want you to know I don't want you jumping at her.

MR. FERLEGER: I want her to realize that Mr. Roth is objecting for the record as permitted, and you are required to answer.

We don't have a Judge here to rule.

(13) MR. ROTH: But you are permitted to elaborate.

BY MR. FERLEGER:
Q. (Continued) The initial examination after the application—the one you referred to usually by a member of your staff—what is the usual length of time for that examination?

A. We should qualify it and say the examination is by a psychiatrist, not any other discipline, and the length of time is variable. It depends on the individual psychiatrist and whether the child is interviewed alone or with a family member present—anywhere from an hour to three quarters of an hour. On occasion, if it is not done by other staff, it may be the same period of time or shorter.

Q. In a court commitment under Section 406 of the Act, as you probably know, the first part of the procedure involves, usually—the person is not then hospitalized—it involves just lay testimony, is that right, somebody presents a petition?

MR. ROTH: I object to that as being argumentative, and calls for a conclusion of law as to what a 406 commitment is.

(14) BY MR. FERLEGER:
Q. (Continued) I will ask it this way.

When a juvenile is committed under court commitment, you testified that those persons are referred to you, haven't you?

A. Yes, I have.

Q. After you testified—in your experience, very often the court commits the juvenile for a period of 10 days for evaluation and observation; isn't that correct?

A. 10, 30, 60, or an indefinite period.

MR. ROTH: I object to your line of questioning, based on—

BY MR. FERLEGER:

Q. What I mean is this. There have been occasions, haven't there, when the first time you saw a juvenile, the subject of a 406 petition, is when the court committed him to Haverford State Hospital, and directs the hospital to evaluate and observe that person, and after doing this evaluation and observation, you then go back to Harrisburg and report your findings?

A. That happens on occasion, yes.

Q. And that period of time that you have the juvenile for that observation and evaluation is 10 days?

(15) MR. ROTH: Objection to this line of questioning, again, based upon the fact the question is argumentative. Also, by asking that question, you are trying to mislead the witness.

BY MR. FERLEGER:

Q. (Continued) Those occasions when you have gotten the juvenile from the court, when you first see the court—when you get the court papers and records, and are told that this is a court commitment to evaluate and observe—those occasions have happened, haven't they?

A. Yes.



Q. In that case, at some future point, you have gone back to the court and told the court or Master your recommendations and evaluation?

A. Correct.

Q. That takes how long, from the time a person comes in under Section 406 and the time recommendations are made to the—

MR. ROTH: I object to this questioning, again, based upon the fact, number one, the specific question is misleading. The issue is commitment under 402 and 403. Counsel is trying to mislead and draw a parallel between 406 and (16) 402 and 403. Furthermore, if I understand correctly, juveniles 18 and under, 406 applies to everyone.

BY MR. FERLEGER:

Q. (Continued) Answer the question.

A. Your question is: how long does it take? I have to answer you: it takes as long as the court specified. It may be 10. It may be 30. It may take 60. It is specified on the commitment by the court.

MR. ROTH: May I cross-examine at this point, or do I have to wait until the end?

MR. FERLEGER: I think we should wait.

MR. ROTH: Fine.

BY MR. FERLEGER:

Q. Of the juveniles now in your care at Haverford State Hospital, can you tell me how many are committed under Section 402, how many under 403, and how many under 406?

A. You'll have to allow me a moment to count.

Q. Do I have a copy of the document in your hand?

A. You have a copy.

MR. ROTH: That question has already been answered, to which you commented on and we replied to. It is a matter of record. You (17) can find your answer there, too. Furthermore, the current status, as I understand your question—

A. (Continued) I can't answer you currently, as I am answering as advised by your staff, to take the word "currently" to apply to the date we received notification of your deposition.

Q. Whatever you have on your list and what is the date?

MR. ROTH: As long as the date is reflected, and you can answer that approximately.

BY MR. FERLEGER:

Q. (Continued) Do you have a list with you today of the juveniles at Haverford, their ages and commitment sections?

MR. ROTH: Objection. I would appreciate her answering one question at a time.

MR. FERLEGER: I withdraw my previous question.

BY MR. FERLEGER:

Q. (Continued) Do you have a list here today?

A. Yes, I have such a list.

Q. May I have such a copy of it?

A. You may have a copy, but not now, because I don't (18) have one. We have a copy of the data abstracted from all the charts, so to have the information.



MR. FERLEGER: We can save some time if you are agreeable that when I make a copy of this list, that can be adopted as part of her testimony.

MR. ROTH: I would like to see the list. I would like to—am I correct in assuming the people whom you are representing, Mr. Ferleger, have given you their consent to see any records or charts about them; in other words, not only representing them in name, but in substance, and they have given their consent for you to see any information about them?

MR. FERLEGER: Yes. Our complainants have given us authorization, and the hospital to release records to us.

MR. ROTH: As part of the record, if any patient comes against the record to indicate—as you have indicated on record now—that you have full consent of every patient whom you represent?

MR. FERLEGER: That's absolutely correct.

(19) MR. ROTH: Through the patient himself?

MR. FERLEGER: Through the patient.

MR. ROTH: As far as I am concerned, you can make a copy now. I notice that Dr. Armstrong has notes on the back of this. I would appreciate that just the actual typing and not her notes be copied.

MR. FERLEGER: For the record, these are two sheets of paper titled, "Class Action Suit," on which are four columns: Names, Age, Commitment, Assigned.

This will be marked as Exhibit A for identification.

(A document entitled, "Class Action Suit," was marked for identification as Exhibit A.)

BY MR. FERLEGER:

Q. Dr. Armstrong, the named plaintiffs in this case, Kevin Bartley, Steve Gentile, Leslie Levine, Vicki Mathews, and Mark Weand, are you familiar with these people?

A. Yes, I am.

Q. They have been patients at the hospital?

A. Yes.

Q. Have you consulted and read their medical records?

(20) A. Yes, I have.

Q. I would like to ask you a little bit about those people.

Kevin Bartley was committed, wasn't he, on November 30, 1971, by his mother?

A. That's correct.

Q. From your knowledge of him at the time he was committed and the time after that, he would have preferred not to have been in the hospital?

MR. ROTH: Objection.

A. Kevin—

MR. ROTH: Do you want to rephrase your question?

MR. FERLEGER: No.

MR. ROTH: Do you want to repeat it, please? I would like to hear it again.



BY MR. FERLEGER:

Q. At the time he was committed and after that, Kevin would have preferred not to have been at the hospital; isn't that correct?

MR. ROTH: Objection. First, I think I would like to make certain under what section Kevin Bartley came. Has that been established?

MR. FERLEGER: I think it can be (21) established by Exhibit A.

MR. ROTH: You are referring to a specific case. You ought to refer to the commitment procedure utilized.

What commitment procedure?

MR. FERLEGER: That wasn't part of my question. If you want to, you can ask that on cross-examination.

MR. ROTH: You better first get to whether he was committed or admitted.

MR. FERLEGER: That has nothing to do with whether he has objected.

MR. ROTH: You have asked whether he objected to commitment. The question is whether or not he was admitted or committed and the appropriate section.

BY MR. FERLEGER:

Q. (Continued) Do you know under what section Kevin Bartley was admitted or committed?

A. He was committed under Section 403 by his mother.

Q. On November 30, 1971, do you know?

A. That's correct.

Q. Was that against his will or with his will?

A. There is no evidence in the admission note or in
(22) his chart that indicates in writing that he objected.

Q. Dr. Armstrong, we are not confined to the record. I am asking you of your own personal knowledge of him.

MR. ROTH: Objection.

MR. FERLEGER: I haven't finished my question.

MR. ROTH: I know. I am objecting to the line of the question.

Go ahead.

BY MR. FERLEGER:

Q. (Continued) Of your own personal knowledge —first of all, do you know what Kevin looks like?

A. Certainly.

Q. Have you spoken to him?

A. Yes.

Q. Were you a psychiatrist at the hospital?

A. I was the director of the services under which he was under. Dr. Carl Hammer was the individual psychiatrist.

Q. Have you spoken, during the course of his stay, to Dr. Hammer about Mr. Bartley?

A. Certainly.

Q. Of your own knowledge, was Kevin Bartley willing and happy to stay at the hospital?

(23) A. Are you asking if he verbally expressed to me a desire to leave; is that your question? I don't follow your question.



Q. Of your personal knowledge, was Kevin Bartley a willing patient at the hospital?

MR. ROTH: Objection. Willing for what?

MR. FERLEGER: Willing to stay at the hospital.

MR. ROTH: Objection. My objection is based on the point, you can't ask another question unless you withdraw your other question: whether Kevin Bartley, after he was committed, immediately objected to it. She answered he had not, and you asked her whether he was a willing patient. My question is: which question do you want the doctor to answer? I object on the basis that if you are going to ask questions, let her answer them.

MR. FERLEGER: I have been waiting for an answer for a little while.

MR. ROTH: But you have asked two questions.

MR. FERLEGER: I asked more than two.

MR. ROTH: On this particular phase.

(24) BY MR. FERLEGER:

Q. (Continued) On Kevin Bartley, my first question is: was he a willing patient at the hospital? In other words, did he desire of his own volition to remain at Haverford State Hospital to get treated with whatever services your unit provides?

A. Then, I can answer you: yes and no. On occasion, he wished to go home with his mother, who, until approximately a month ago, did not wish him at home,

and on other occasions, he requested to stay. So, both are true: yes and no.

Q. Isn't it true; had it not been for his mother making the application, had it not been the fact that she had initiated the commitment, that he wouldn't have stayed there?

A. No, that's not true. He stayed until it seemed advisable, until he attained sufficient ego control and behavior control. He was given to explosive outbursts.

Q. Did he think he had a problem with his ego control?

A. He thought he had a problem controlling his temper.

Q. He stayed because it was medically advisable?

A. Psychiatric.

(25) Q. He needed to stay at the hospital because of a psychiatric opinion?

A. Well, I would say he did not accept this. We do fulfill the psychiatric needs through the care and facilities of the hospital.

Q. Did he disagree with that psychiatric opinion?

A. On occasions.

Q. Even when he disagreed—

MR. ROTH: Objection. You are harassing the witness.

MR. FERLEGER: I am in the middle of a question.

MR. ROTH: You are harassing the witness. You are going over the same question three times.

MR. FERLEGER: You don't know the end of this question. I am in the middle of it.



BY MR. FERLEGER:

Q. (Continued) Even at the time he objected, he would not have been free to leave the hospital, isn't that true?

A. No, that is untrue. The mechanism is set up for giving notice, providing that the applicant was willing, he would have been signed out against medical (26) advice, even though determined medically and psychiatrically that he remain.

Q. But under those procedures, if the applicant is unwilling, he couldn't have signed out against medical advice?

A. That's true. I qualified my answer by stating when he was ready to leave, he was in fact discharged and not retained for reasons other than psychiatric.

Q. On long-term leave and—

A. Short-term leave. That, I would like to qualify for the record, is for administrative purposes, in order to provide the child the service he needs, namely, transportation from two counties, to Delaware County Intermediate for specified schooling.

Q. Leslie Levine, do you know who she is?

A. Yes, I do.

Q. When and under what section of the Act was she committed?

A. Leslie was admitted on a 403 commitment signed by her mother on 10/11/72.

Q. Where does her mother live?

MR. ROTH: Objection.

BY MR. FERLEGER:

Q. (Continued) Where does she live?

(27) A. In suburban Delaware County. I will give you the chart.

Q. Where does her father live?

MR. ROTH: Objection.

A. In Florida.

Q. Are her parents married, separated or divorced?

MR. ROTH: Objection.

A. Divorced.

Q. You read her records, didn't you?

A. Yes.

Q. You read her records and also the other patients' under your care?

A. In compliance with your order, we have prepared summaries specifically for this deposition on all adolescents in the hospital, including the plaintiffs and all others, which includes those not under my care.

Q. May I have them, please?

(Discussion off the record.)

(Copies of patients' summaries were handed to Mr. Ferleger.)

BY MR. FERLEGER:

Q. Dr. Armstrong, I have received from you and your counsel summaries of the commitments of every juvenile now in your unit, or in your unit as of February 15th.

(28) A. In the entire hospital.

Q. Thank you. In the entire hospital at Haverford State Hospital as of the date noted, I suppose, on the summaries; is that correct?

A. No, as of Mr. Abramson's advising us, the date we received your deposition request. What is that, February 23rd?



MR. FERLEGER: I also received dated summaries of the named plaintiffs in this lawsuit.

For the record, for the named plaintiffs, as I said before, I received their consent to seeing their records.

(Discussion off the record.)

MR. FERLEGER: For the record, there are individuals whose brief summaries I have been given from whom we have not received specific consent. These are individuals who are 18 years of age or under, and who have been ordered by the court, members of the class, plaintiffs of this lawsuit.

MR. ROTH: I would just like the record to reflect—and Mr. Ferleger can correct me if I am wrong—that from the statement he has made previously, he has received the consent of (29) all patients to receive and review their medical charts and all material relating thereto.

MR. FERLEGER: I have received consent to look at records of both juveniles and adults at the hospital in two ways. With respect to the named plaintiffs in this case, I received, on individual sheets of paper signed by them, specific consent to see records, and specifying the hospital release those records.

With respect to other persons, including those persons whose summaries will be marked as Exhibit B, I have received consent to see their records by reason of a contract with Haverford State Hospital, approved by Dr. William Beach, a defendant in this case, Deputy Secretary for Mental Health of Pennsylvania, which allows access to all patients' records at the hospital.

MR. ROTH: I would like to make a statement. In addition thereto, I have been informed by—and perhaps misled by—the opposing counsel, that he had received consent from all patients in this case, which included permission to receive and review their records. With regard to viewing these records, and having (30) given these records under the belief and assurances by opposing counsel that he had received the consent of the patients, I hereby charge that unless he has received that consent, that those records are subject to the rules of confidentiality.

MR. FERLEGER: For the record, plaintiffs certainly agree to abide and respect the confidentiality of patients who plaintiffs represent and the plaintiffs in their class in this matter.

The contract with Haverford State Hospital, approved by Dr. William Beach, signed by Dr. Kremens, and approved by Mark Leopold, Assistant Attorney, in Paragraph 11, the hospital agrees to give access to all patients' records and to all areas of the hospital to its professional staff and members. We will abide by the same rules governing hospital personnel having such access.

My questions now are directed to specific summaries of the named plaintiffs from whom we have specific consent, which will be marked as Exhibit C.

(Individual patient summaries were (31) received by Mr. Ferleger from Dr. Armstrong and marked for identification as Exhibit B.)

(Individual patient summaries for named plaintiffs were received by Mr. Ferleger from Dr. Armstrong and marked for identification as Exhibit C.)



BY MR. FERLEGER:

Q. Dr. Armstrong, the statements in all these exhibits are true, aren't they?

A. Yes.

Q. As far as you know?

A. Yes, as far as I know.

Q. You are willing to incorporate them into your testimony?

A. Yes.

Q. With that, we can dispense with reading over every word?

A. Fine.

Q. With reference to Leslie Levine who was at Haverford, do you know where she is now?

MR. ROTH: Objection.

A. No, I don't.

Q. Do you know if she went to Florida to live with her father to complete the school year, as done in the (32) past?

MR. ROTH: Objection. The witness has already answered your question as to where she is since she left the institution.

BY MR. FERLEGER:

Q. Do you know if the patient and her mother agreed to your recommendations to individual therapy while living with her father in Florida?

MR. ROTH: Objection. There has been no foundation laid on this.

MR. FERLEGER: Yes, if this summary of Leslie Levine is true.

MR. ROTH: If you are going to indicate a part of it, indicate the foundation for it.

BY MR. FERLEGER:

Q. (Continued) Have you read the summary?

A. Certainly.

Q. Did you help prepare it?

A. Certainly.

Q. Did you in fact prepare it?

A. No.

Q. With reference to Leslie Levine and with reference to the summary and with reference to what actually happened to her, to your knowledge from medical records, (33) did Leslie and her mother agree to the hospital's recommendation of individual therapy while living with the father in Florida?

MR. ROTH: Objection.

BY MR. FERLEGER:

Q. (Continued) Will you answer?

MR. ROTH: No. I want to elaborate.

First, you have just admitted a summary of this person.

Second, you indicated you did not want to go through the summaries with her verbatim, and have already asked Dr. Armstrong if the summaries are true and accurate to the best of her knowledge, and she has answered yes.

Now, you are taking the summaries and admitting or deleting parts of them, and also asking questions about the child's care and treatment subsequent to her release from the institution.



MR. FERLEGER: No, I wasn't. All I asked is if she and her mother agreed to something. I didn't ask if anything happened to her after.

MR. ROTH: Would you like to make a statement of proof?

(34) MR. FERLEGER: No.

MR. ROTH: Then I wish to register a special objection.

BY MR. FERLEGER:

Q. (Continued) Answer the question.

MR. ROTH: Please repeat the question.

BY MR. FERLEGER:

Q. Leslie—do you know her mother's name?

A. Her first name?

MR. ROTH: Objection. It's not relevant.

BY MR. FERLEGER:

Q. Her last name is Levine?

A. Yes.

Q. While Leslie Levine was at that hospital, did Leslie and Mrs. Levine, her mother, wish the patient to live with her father in Florida?

A. Mr. Ferleger, I will answer your question by stating that at the last family conference with Dr. Lustig, who was Leslie's individual and former therapist, they agreed that she would live with her father upon discharge and then they would follow the child on individual therapy. That's the extent of my knowledge.

Q. Why didn't she go home to live with her mother?

A. As the summary indicates, part of Leslie's (35) diagnosis of adolescent adjustment reaction, was extreme

difficulty functioning within her mother's surroundings and with the siblings. It was not psychiatrically wise to repeat that living experience.

Q. And she did better with the father?

A. That's what the history indicates.

Q. With reference to Mark Weand, he was committed under Section 402, June 23, 1972, isn't that true?

A. I have June 24th.

Q. At that time, did he wish to become a patient at Haverford State Hospital, to your knowledge?

A. At the time of his admission he was exhibiting symptoms of being under the influence of unknown drugs—

Q. Can you answer this question, please—

MR. ROTH: Let her answer.

A. He was not able to respond appropriately to any external stimulus.

Q. Your summary doesn't show that he was not able to respond to external stimulus.

A. It says, "Still intoxicated."

Q. It says, "Extremely hostile."

A. I would say being intoxicated.

Q. "Being intoxicated," does that mean you can't respond to any—

(36) A. It does mean any. I would say so.

Q. Subsequently, he was referred to and seen by a psychiatrist?

A. Right.

Q. At the time, did he desire to remain and become a patient at Haverford State Hospital?

A. I can't answer that question. I don't know at that time.



Q. What was the first time you saw him?

A. As indicated in the record, he was placed in a closed unit and was seen by Dr. Harold Rashkis.

Q. What is the first time you saw him?

A. I was answering. When he was transferred to the open unit on 7/12, I then saw the patient.

Q. At that time, did he wish to remain at Haverford State Hospital and remain a patient there?

A. You will have to tell by what indications you wish. He gave no indication, written or oral, to the staff. He indicated—I have the date as approximately two months thereafter—that he wished to leave. At that particular time there was no written or verbal expression made.

Q. At that time later, two months, was he permitted to leave?

(37) A. At that time, for the record, he wrote to the Adolescent staff, not the hospital director, and he was not permitted to leave. It was felt he was not ready to leave, psychiatrically.

Can I add to my answer?

Q. Yes.

A. In addition, it is to be noted that approximately two months thereafter, on September 3rd, the patient was suspected of taking an overdose of drugs.

Q. Dr. Armstrong under some questions I am sure your counsel will ask on cross-examination, and it will save us a lot of time if you try to answer my questions and not anticipate things or add things.

MR. ROTH: I really don't think you can elaborate on a question you ask her.

MR. FERLEGER: Of course not. The fact that he attempted to take an overdose of drugs doesn't

mean anything about the staff not allowing him to leave.

MR. ROTH: Dr. Armstrong, you just answer his questions, no more, no less.

BY MR. FERLEGER:

Q. (Continued) Just in general, in your experience at Haverford State Hospital, there are some children (38) who are happy to be there and happy to get care, and there are some who aren't and don't want to be there?

A. No, I don't think anybody is happy to be in a mental hospital. There are some who are willing to admit that they have problems and who want care, and there are some who aren't willing.

Q. So, there are some who desire to be there and want to get treatment, and some who don't desire to be there and don't want treatment?

A. That's true.

Q. Some of these persons, juveniles, are committed there by courts; isn't that true?

A. True.

Q. Some are either signed in on application of their parents; isn't that right?

A. That's right, true.

Q. There are a number of individuals in your unit who have come in, juveniles, because they want to come in themselves; isn't this true?

A. They are.

MR. ROTH: Objection. I am sorry, counselor. I am not sure I understand the question. If I don't understand, then Dr. Armstrong may not.



(39) BY MR. FERLEGER:

Q. Are there some juveniles who have problems, who appeared stating, "I need psychiatric help. I want to be a patient"—who presented themselves, without their parents?

A. Yes.

Q. Are they accepted as patients?

MR. ROTH: Objection. Can you indicate what you mean by "juveniles"?

MR. FERLEGER: For all purposes, when I say "juveniles," I am referring to persons 18 years of age or under.

BY MR. FERLEGER:

Q. (Continued) Are people like that admitted?

A. They can only be admitted under the Mental Health and Retardation Act, which means that they must have someone, either a parent or guardian, and in the absence of either, someone to make a loco parentis application for them to get in.

Q. So, persons 18 years of age or under who wish to be committed and their parents refuse to make application, you don't take them in as patients?

MR. ROTH: Objection. I think the question has already been answered.

(40) BY MR. FERLEGER:

Q. (Continued) You can answer it.

A. There are methods by which we can.

Q. What methods?

A. We would contact the parents and contact the county agency, in this case, the Child Care Agency of Delaware County, and attempt to have guardianship

changed from parent to agency, and have the agency commit the child.

Q. Over the past four years, how many times has that happened?

A. I can't give you a number.

Q. Approximately how many per year?

MR. ROTH: I will register an objection.

A. I am not good at making estimates. It happened not infrequently. I can't give you a number.

Q. In your treatment program of juveniles, do you have a different program for court committed patients, as opposed to patients who are committed under 402, or 403, or is it the same program?

MR. ROTH: Objection. I would like counselor to specify whether people are treated differently, if that's what he is getting at, in terms of psychiatric help; is that your (41) question?

MR. FERLEGER: By treatment, I mean professional psychiatric programs.

MR. ROTH: You are asking about professional—you are asking about whether participation varies according to what section of the law—

MR. FERLEGER: That is a better phrasing.

MR. ROTH: Fine.

A. No. The program is set up to meet the needs of individual children, and the type of commitment has no bearing, except wherein the child—let me see how you should record this. You will need a closed facility for approximately a year or longer for someone who is committed under a murder one charge. Otherwise, for 408 or



406 court commitment: are treated, given ground privileges, and accessability to adolescent closed and open buildings, as their condition indicates.

Q. As their condition indicates, except for extraordinary cases, some criminal charge or court orders, otherwise it makes no difference what section the person is committed under?

MR. ROTH: Objection. You are misleading the witness.

(42) MR. FERLEGER: Why doesn't she tell me?

MR. ROTH: You are just taking her answer and turning it around to mislead her. I object to her answering that at all. You are misleading her completely. She just testified, as I understand it, that it depends on the needs of the person who is admitted—if you heard the beginning.

BY MR. FERLEGER:

Q. Then when you say, "Depending on the needs of a particular patient," then you are—

MR. ROTH: Are you going to specify the specific sections and use that, or I feel I must reject the premise of your question.

MR. FERLEGER: If Dr. Armstrong is mislead, I am sure she will tell you.

THE WITNESS: Okay. I am mislead.

BY MR. FERLEGER:

Q. (Continued) Thank you. Your answer earlier, with reference to—concerning whether the professional treatment program differs upon the court commitment,

what I understood you to say is that except in certain exceptional circumstances— the example you gave us is someone who needs a closed facility because of a (43) murder one charge—except in those exceptional circumstances, the treatment does not vary because of the type of court commitment—voluntary or court commitment?

A. Isn't that what I said?

Q. I am asking you.

A. That's what I said.

Q. Now, in your experience, what relationship have you seen between the progress and outcome of the treatment of juveniles with reference to whether they were committed by court or committed through application of the parents?

A. I can't answer that. The only way I could tell is if we did adequate research.

BY MR. ABRAMSON:

Q. Along that line, but not trying to ask a question that might require extensive research, when you have your meetings with different patients that come under the adolescent unit—

A. Adolescent Service.

Q. —Adolescent Service, do you seem to get the impression from them there may be some antagonism, based on the manner in which they were committed? Should I explain that more?

(44) A. Yes.

Q. In other words, what I am getting at: you meet with juveniles and you see them in your office personally, as I understand it, and you also observe them in the building, and I believe you have also seen all the patients who are currently there as of February 23rd. So, what I am sort of getting at is: do you feel you ever get any feedback



from them with reference to the manner in which they were committed? Do they complain to you or give any specific comments about the commitment procedure? Do they feel any abuse as far as they are personally concerned? Do you get any kind of a feedback from young people?

MR. ROTH: I object to this line of questioning. It is completely irrelevant on the fact there are provisions in the Mental Health Act which qualify why a person is court committed.

I even question whether or not there is any relevancy at all to this line of questioning.

I would request an offer of proof.

BY MR. ABRAMSON:

Q. (Continued) Answer the question.

A. Did I notice as the administrator of the unit, any difference in the attitude of the kids toward their (45) treatment, with reference to the kind of commitment?

Q. No, sort of getting away from the distinction between types of commitment now.

The fact that you are there on a permanent basis, and you have certainly, I believe, a great deal more contact with the patients, especially with the juvenile patients, than we do—

A. I have contact only with juveniles.

Q. —in that sense, I thought you might be able to enlighten us as to any feedback that you have received from juveniles in reference to their commitment, whatever section they were committed under; do you ever have comments from them?

A. Whether they are placed there against their will or with their will?

MR. ROTH: I object. I think Dr. Armstrong has answered that in a general term before, when you said whether people like to stay at the institute or not. I think she adequately answered that. You are giving a general question, yet you want her to answer it specifically.

MR. ABRAMSON: Perhaps I can be more specific.

(46) BY MR. FERLEGER:

Q. Can you answer the question?

A. No, I can't. I don't understand it.

BY MR. ABRAMSON:

Q. Have you ever had one of the juvenile patients make a statement to you concerning the manner in which he was committed?

A. Certainly.

Q. Have these statements from juveniles, minors, concerning the manner in which they were committed, ever reflected any dissatisfaction on their part?

A. Certainly.

Q. Do you feel, professionally speaking, the manner in which they were committed may have had a negative effect on their psychological well-being or mental well-being?

MR. ROTH: Objection.

BY MR. FERLEGER:

Q. Can you answer it?

MR. ROTH: The objection is founded upon the basis of the Act itself, where the hospital doesn't admit anybody it feels doesn't need help.



MR. FERLEGER: Dr. Armstrong can still (47) give her personal opinion.

A. The manner in which they are committed hasn't any negative effect on their psychological well-being.

I think the only way I can answer your question is to address myself to the question of someone's being there of their own volition or not being made available of the treatment, and it makes no difference under what manner one is committed, be it loco parentis, or parent, or court. Whatever the circumstance, when someone is unwilling to accept treatment, it is difficult to treat them. The fact they are unwilling is negative psychologically, not the manner.

Q. Thank you. Dr. Armstrong with reference to juveniles who were signed in by their parents at the hospital, do you think you just, professionally, would have a better chance to treat these juveniles if they were committed by the court, as opposed to having been signed in by their parents?

MR. ROTH: Objection.

A. I would have to answer that question the way I answered previously. In my professional opinion, where I am not concerned with the legality, but the treatability of an individual, it matters to those of us as therapists, whether the person presents himself (48) as willing or unwilling. The agency that does the unwilling commitment is not so relevant.

Q. So you don't think it makes such a difference whether the juvenile is committed by his parents, as opposed to having been committed unwillingly by the court?

A. I am sure it makes a difference.

Q. What difference?

A. By the fact that parents—and parents on whom they thrive—have a psychological attachment to their children.

Q. What is the difference—do people have—to children, as opposed to the court, which has no psychological attachment?

I know that is a difficult question.

A. I'm afraid it depends on the individual case.

Q. In cases where you experienced contact, can you tell me what difference it makes to the particular child?

MR. ROTH: Objection. You are going on hypotheticals.

MR. FERLEGER: I am asking on a specific instance.

MR. ROTH: What instance are you referring (49) to?

MR. FERLEGER: In specific, the instance of the children mentioned in Exhibit A.

MR. ROTH: Mark Weand or the entire list?

BY MR. FERLEGER:

Q. (Contniued) Just, if you would, like, outline for us, in your discretion, persons signed in by parents—tell us what difference it made to them in their case or their treatment, whether they were committed by their parents, as opposed to court?

A. The only way I can answer that is to go into each and every individual case. I couldn't generalize. There is no way I can give a generalized statement.

MR. ROTH: I object to the whole line of questioning. What you are doing: you are asking her for



an assumption of how it differs for one who is court committed, how it differs for one voluntarily committed, and how it differs for one who is court committed, and I think the rules speak for themselves, in commitment procedures. She has indicated several times it is impossible to answer that question.

MR. FERLEGER: I am asking for her (50) professional opinion, not an assumption.

BY MR. FERLEGER:

Q. In the Leslie Levine case, that is the case where I understand she didn't get along with her mother and siblings, and her mother is the applicant for her commitment. In that case, would it have made any difference to her or to her treatment if the court had committed her, as opposed to her mother applying for her commitment?

A. I can't answer that. That presupposes knowledge I don't have. In qualifying the admission, it was not because she didn't get along with her parents or her mother, but she can't behave appropriately. Specifically, she chased her mother with a kitchen knife and threatened to kill her.

I can't answer that it matters what agency committed her.

Q. Do you think the hostility that she evidenced toward her mother was increased or decreased by the fact her mother surrendered her to the hospital against her will?

A. My judgment is that it would be increased. Whether that in fact occurred, I can't say.

Q. Wouldn't there be less or an increase in hostility (51) or none at all if an impartial court admitted her?

A. I don't know.

MR. ROTH: Objection. She has answered that question repeatedly now.

BY MR. ABRAMSON:

Q. Dr. Armstrong, I notice on the list of juvenile patients, which was labeled Exhibit A, names of two young people in particular that attracted my attention. I would like to direct questions about them.

One is a young man, Allen Moss, whom I believe is currently still at the hospital.

A. That's correct.

Q. Specifically with reference to Allen, has he indicated to you or any member of your staff any facts with reference to the manner in which he was committed? Perhaps I should add the exhibit also shows he was committed under Section 403 of the Mental Health and Retardation Act. His records would show that he was admitted by his parents; is that correct?

A. That's correct.

Q. Has he indicated to you or members of your staff, any specific comments concerning the manner in which he was admitted?

A. I have not heard of any. Mr. Moss is directly (52) the patient of Dr. Gus Kratsa, K-r-a-t-s-a. Whether at individual therapy he has given some indication, I don't know.

Q. In other words, in the summary, there are no notes making reference to his original admission to the hospital or anything that took place at that time?

A. There are no notes in the summary.

I can add he was transferred from the University of Pennsylvania, and he admitted to being depressed and suicidal.



Q. Doctor, with reference to the third female patient, Deborah Geiger, the exhibit shows her age to be 16, and the type of commitment, under Section 403 of the 1966 Act, and I believe the specific record of her commitment shows she was also committed by her parents.

A. The record so states, Mr. Abramson, however, it also indicates that she wished to be committed, and it was impressed upon her by Dr. Kratsa that under the Mental Health Act, it was necessary that her mother sign her in.

It is a general requirement of the Mental Health Act that we ask the juveniles to sign the 403 paper themselves.

(53) Q. But Allen Moss, how did he come to get to the hospital?

MR. ROTH: Objection.

BY MR. FERLEGER:

Q. How did Allen Moss come to be a patient at the hospital?

A. The social worker from the University of Pennsylvania called our in-take social worker and arranged a transfer from the University. He was deemed to be too suicidal to remain in their setting, which is not a psychiatric hospital. He was in their ward.

Q. Then his parents signed him in?

A. Yes.

Q. When did his parents sign him in, as of what date?

A. As of 1/10/73.

Q. When was he transferred physically from the University of Pennsylvania?

A. The same day.

BY MR. ABRAMSON:

Q. So that I can assume then, the specific records that you have, the summary for Deborah Geiger, don't indicate anything with reference to her admission, other (54) than the comments you have already made?

MR. ROTH: Objection. That is misleading, Mr. Abramson. You indicated, "according to specific records of the summary."

MR. ABRAMSON: I am sorry.

BY MR. ABRAMSON:

Q. (Continued) According to the records of the summary you have here before you, doctor, can I assume then, other than the comments you have made, there is nothing else making reference to what took place at that time?

A. No, you can't assume that. The entire chart has additional data. I have extracted some material.

Q. The summary doesn't show additional information concerning her admission?

A. You have a summary before you. I don't see that it has any additional information.

Q. From your knowledge of her specific chart, do you recall any specific information on her chart concerning her admission; from her chart, which is not with us today, do you recall any specific information concerning her admission?

A. That she expressed a desire to Dr. Kratsa to come to the hospital. It's present on her admission, (55) yes.

Q. From your personal knowledge, could you convey any other information concerning her admission, other than what you have already given us?

A. What kind?



Q. Concerning the manner in which she was admitted, her attitude at the time, any facts?

A. She was interviewed in the open unit. Her family was subsequently interviewed, and she requested admission as an alternative to running away. She was considered to be quite upset, despondent, and in need of some treatment, and perhaps the living facilities of the hospital were available and the open unit was offered to her, which she accepted.

Q. Do you recall any information which has come to your attention from a member of your staff concerning the manner in which her parents made her available to your staff at the hospital; in other words, do you have any information concerning how she got to the hospital, other than the fact she came with her parents?

A. Her mother drove her.

BY MR. FERLEGER:

Q. With all the experience you have had with juveniles, would you just tell me—and this is an (56) open-ended question—whether or not you see any reason, or what reasons you do see for juveniles not to be entitled to a 406 court hearing before they can be presented to the hospital against their personal will?

MR. ROTH: Objection.

MR. ABRAMSON: Will you talk to that issue, please?

MR. ROTH: Dr. Armstrong is not qualified to testify on law as you feel it should be.

MR. FERLEGER: I do not wish her to testify on law.

MR. ROTH: You have agreed to her qualifications as an expert witness with regard to her treatment of juveniles specifically, and you have focused on these questions, and in part, you have gone awry.

As far as I am concerned, you are turning this into a fishing expedition. If that is going to continue, I will make the appropriate motion to dispense with the deposition.

BY MR. FERLEGER:

Q. (Continued) Can you answer that question, please?

A. You will need to restate the question.

(57) (The reporter read the last question as follows:

"Q. With all the experience you have had with juveniles, would you just tell me—and this is an open-ended question—whether or not you see any reason, or what reasons you do see for juveniles not to be entitled to a 406 court hearing before they can be presented to the hospital against their personal will?")

A. You are asking for my individual opinion?

Q. Yes, as a human being and psychiatrist.

A. My opinion is only in that area in which I am qualified to speak, and that is quality medical care.

Were the 406 hearing a legal procedure set up to function in a rapid manner, so that the child involved could get adequate care as soon as required, there would be no reason. However, in reality, that does not exist, and I find that insisting upon a court procedure for the admission of an acutely ill child would deprive the child in some instances, in many cases, of rapid institution of adequate psychiatric treatment.



Q. The need for rapid institution and psychiatric treatment could be met, couldn't it, by some emergency procedure, don't you think?

(58) MR. ROTH: Objection.

A. As I understand the present Mental Health and Retardation Act, the emergency procedures under a 405 are extremely difficult to comply with and do not fit all the circumstances in presenting an acutely ill child. Specifically, one must be acutely and observatively homicidal or suicidal and have committed such an act in order to qualify. There are a number of ill children that do not fit that definition.

Q. You said in your answer before, if there was a 406 or other court procedure which would get this effective care quickly for acutely sick children, then, as a professional, that would be satisfactory to you?

A. Are you saying if there was only a court procedure or additional?

Q. If there were two proceedings: one where the child could come in to you and get the care, of his own personal volition, and the other one, where there was a rapid and fair court procedure.

A. I don't think that would, in my own opinion—I think that is too restrictive. I also think there should be a provision for adequately trained medical personnel to effect admission rapidly without requiring a court proceeding.

(59) Q. Would that go to adults as well?

A. I am not qualified to speak for adults.

Q. Are you a psychiatrist?

A. Yes. That's an unfair question, and I am not going to answer that.

Q. You are a psychiatrist?

A. That's correct.

Q. To your knowledge, is there anything different about acute psychiatric problems of adults, which would require that adults also have the procedure you are suggesting, where qualified medical personnel could commit them without a court hearing?

A. I will have to answer your question this way. Yes, I am a psychiatrist, and I have been trained to work with adults first, but I have not practiced adult psychiatry in eight years. There are considerable differences with the acutely ill child, as opposed to acutely ill adult, particularly with reference to the degree of personality growth. Therefore, I can't answer your question.

Q. What are those differences?

MR. ROTH: Objection. This has become a fishing expedition. We are supposed to be focusing on Sections 402 and 403 of the Act. (60) Now you are going off on a tangent about adults and children and are talking in terms of generalities. It is becoming a fishing expedition.

MR. FERLEGER: Mr. Roth, if you will read the complaint, the first cause of action of the complaint alleges violation of equal protection, in terms of the way two classes of juveniles are treated, as well as a difference in the treatment between adults and children.

MR. ROTH: Notwithstanding—

MR. FERLEGER: This is not a fishing expedition to ask questions not only proper on deposition, but even admissible in court.



MR. ROTH: That is questionable, Mr. Ferleger. I appreciate your unrestricted judgment that this is admissible in court.

Secondly, as far as the questions concerning juveniles, along with adults, I believe Dr. Armstrong has already testified, notwithstanding your repeated harassing questions about adults, that she not be asked to testify to the nature of adults treatment or anything of that sort, since she has not been exposed to (61) them for the past eight years, and does treat, specifically, juveniles.

THE WITNESS: We better qualify that. Okay? I will have to change my statement regarding dealing with adults. I certainly deal with adults as far as their being family members, and have, in the past four years, restricted myself to adolescent psychiatry, and no adult patients per se.

MR. FERLEGER: Thank you.

MR. ROTH: Dr. Armstrong does state she was trained first in adult psychiatry. I don't think you would want to impune her qualifications. I am just objecting to your—

MR. FERLEGER: The question I asked her: what are the differences in the acute psychiatric problems of adults versus children—

MR. ROTH: And Dr. Armstrong answered that one of the problems involved is the determination upon permanment development. Now, to go through the whole list of them, I suggest you consult your nearest book on psychiatry and look for yourself, otherwise, it would take forever.

You are talking in generalities. As (62) involved among children, psychiatry is—

BY MR. FERLEGER:

Q. (Continued) Can you tell us any major differences between adult psychiatric difficulties and child psychiatric difficulties?

A. That would, Mr. Ferleger, take the better part of an afternoon. I can't do that. There are multitudinous ego functions that are not developed to the extent that are adults', and to go into each one entirely is too involved.

Q. With reference to those differences in these illnesses between adults and children, those illnesses would make, in your opinion, a sort of different procedure necessary for adults and children?

A. I couldn't say that.

Q. Are there differences between psychiatric problems in children which, in your opinion, would make it essential there be different procedures for bringing them into the hospital?

MR. ROTH: I object to that line of questioning. I think, Mr. Ferleger, or I am—at least I hope I am—well enough aware of the Act to know there are different procedures for adults, as well as procedures for juveniles (63) in the case of their commitments or admissions.

MR. FERLEGER: Mr. Roth, I was not asking for or eliciting your opinions. I am asking for Dr. Armstrong's opinions.

BY MR. FERLEGER:

Q. (Continued) Can you answer that?

A. Tell me the question again.



MR. FERLEGER: Read it back.

(The reporter read the pending question as follows:

"Q. Are there differences between psychiatric problems in children which, in your opinion, would make it essential there be different procedures for bringing them into the hospital?")

A. There are differences between adults' and children's psychiatric problems. We have established that. Whether that, therefore, indicates a different procedure for admission to be followed, I can't answer that.

Q. In your psychiatric opinion—

MR. ROTH: She just indicated she can't answer it.

MR. FERLEGER: Let me try to clarify the question.

(64) BY MR. FERLEGER:

Q. (Continued) Psychiatrically, you can't say then, if I understand you correctly, there are differences which require different procedures; is that a statement of what your feeling is?

A. No.

MR. ROTH: Would you clarify the question, please?

BY MR. FERLEGER:

Q. Would you say what you said then?

MR. ROTH: Say your question.

MR. FERLEGER: My question—there is no need for me to repeat it. This deposition will show what the question is.

She said she can't answer specifically, and I am asking her to state her feelings.

MR. ROTH: She can't answer with a statement. You have asked for her professional and personal opinion.

MR. FERLEGER: Dr. Armstrong was about to say something.

BY MR. FERLEGER:

Q. (Continued) Dr. Armstrong, is your position that you cannot say that there are differences between (65) the mental illness of adults and juveniles, which would require different procedures for admission or commitment to a hospital?

MR. ROTH: Objection. Dr. Armstrong has already answered that question.

A. I didn't say I cannot. What I said was I cannot state, on the basis of the fact there are differences in the kind of problems that children have, as opposed to adults. That in itself, therefore, indicates a difference in admission procedures which should be followed. Certainly the child should be allowed the same facilities as adults. Specifically, children should be allowed to sign themselves into a hospital, assuming they have adequate judgment. This is one of the difficulties in dealing with a child, and what you have to determine upon examination at the time of admission by a qualified psychiatrist. That's one of the major differences, and that's their ability to judge situations adequately.

Insofar as the admission procedure followed, as a conclusion to the assumption and statement, there are differences between mental illness in children and adults, but I can't answer as to the procedure.



Q. In your opinion, do you think the judgment of (66) parents, or guardians, or persons standing in loco parentis is sufficient for proper commitment of children to mental hospitals?

A. I think, under the Mental Health and Retardation Act, at the time the child is examined—

Q. In your opinion, not under the Mental Health Act.

A. I think the answer is yes and no.

Q. Can you explain that?

A. There are some instances where the parents are qualified, the child would not be admitted, which is my answer, under the Mental Health and Retardation Act—the parents would be judged to be qualified. However, on occasions, parents' judgments could be questioned.

Q. Unless the professional person, you included, felt the parents were qualified to make the determination?

A. Certainly. To elucidate, a psychotic parent could not admit a child because he would be judged not to be competent to judge.

BY MR. ABRAMSON:

Q. In your experience at Haverford State Hospital —in your professional experience, can you recall any (67) specific incidents of what you would consider abuses of the admission procedure by parents of young people?

A. I think you are referring to a conversation we had, Mr. Abramson, in checking into the particular cases. The child we were discussing, I believe, was committed under Section 406, so I can't recall that.

Q. You can't recall any case in which a parent has, under Section 402 or 403, for reasons other than the best interests of the child—

MR. ROTH: Objection. I believe Dr. Armstrong has answered the question.

MR. FERLEGER: It was not asked. I believe she has answered that according to the Mental Health Act at the time when persons under 18 are admitted, those doing the application are judged to be competent.

BY MR. FERLEGER:

Q. Once those persons are judged to be competent, then the child is admitted?

A. If the child appears to need admission.

Q. Have you, in your experience, ever come across an incident—I want you to think about this carefully—where parents have used the fact that they were able to petition and could apply under 402 and 403—have (68) used that fact in order to manipulate the child or the Act, contrary to the psychiatric interests of the child?

MR. ROTH: Objection. That question has been asked and answered.

BY MR. FERLEGER:

Q. (Continued) Can you answer that?

MR. ROTH: Furthermore, on the basis of harassing the witness.

A. That is a difficult question to answer. At the same time, I don't know if you are referring to the Exhibit A list.

Q. I am not referring to any exhibit list. I am referring to your past four years at Haverford State Hospital.

A. I don't know. I can't attempt to give you an answer, no. I am sure it occurs.



BY MR. ABRAMSON:

Q. In reference to that statement, do I understand you to say the present admission procedure, as followed by Haverford State Hospital, in accordance with the Mental Health and Retardation Act, allows for such abuses in your opinion?

A. No, it doesn't, because the child is examined on admission, and that has to be based on a qualified (69) psychiatric determination that the admission is necessary psychiatrically.

Q. I think that, Doctor, what I am asking is: does the procedure as followed by Haverford State Hospital, in accordance with the Mental Health and Retardation Act, allow for abuses, not on the part of the hospital or on the part of the admitting physician or whatever, but on the part of the parents? In other words, in their motivation.

MR. ROTH: Objection. The question has been asked and answered.

BY MR. ABRAMSON:

Q. (Continued) I am not asking now for any specific incidents or anything like that. I am asking for your personal opinion as far as the procedure goes, whether it allows for abuses, not on the part of the hospital, but on the part of parents who signed it, to apply as a part of the admission process. They do speak to the admitting physician; they do have the opportunity to convey their thoughts and their opinions about their child or are given some consideration by meeting the physicians. Given those facts, as I understand them, does the doctor feel, personally, that the procedure allows for abuses on the part of parents, again, not on (70) the part of the hospital?

A. I don't think that that's an adequate question, because the child is examined by a qualified psychiatrist, and were the child, regardless of what the parents stated, not in need of hospitalization, the child would not be hospitalized.

BY MR. FERLEGER:

Q. Stopping short of the decision of whether the child is in need of hospitalization, let's assume you have examined the child and you decided, does the procedure, as Mr. Abramson asked you, allow for abuse, even in initiating the application?

MR. ROTH: I object to that question. Dr. Armstrong is a psychiatrist who examines and determines whether or not the patient is a prospective patient, let's put it that way, and is in need of institutional care. What motives are behind the parents' placement of the child into the institution is completely out of the scope and knowledge of Dr. Armstrong. She is not dealing with the parents in admitting the child.

MR. FERLEGER: You heard she does speak to the parents.

(71) MR. ROTH: But you are trying to use that as a weapon in saying the parents are abusing the procedure.

MR. FERLEGER: I am not saying that.

MR. ROTH: That is completely out of the scope of this deposition. Dr. Armstrong can, not only testify as a professional involved, but also in terms of whether or not the prospective complainant needs to be admitted.



BY MR. FERLEGER:

Q. (Continued) We haven't given her a chance to answer that question.

A. I can answer you only insofar as what I said before. The parents' motives are examined. The child also is examined, and if his admission is determined to be necessary, admission takes place.

Q. You have examined parents' motives?

A. I interview parents.

Q. And professionally, you consider their motives and try to make an evaluation of their motives?

MR. ROTH: Objection. Dr. Armstrong discusses the admission with the parents. She does not examine the motives of these parents, and these inuendoes made are incorrect.

(72) BY MR. FERLEGER:

Q. (Continued) Do you examine the motives of the parents? I think you stated you—

MR. ROTH: She does not. If you are going to mislead, I am not going to let her answer.

BY MR. FERLEGER:

Q. (Continued) Dr. Armstrong, do you understand what the word motives means?

A. You can explain it to me.

Q. Do you not examine the motives of the parents who seek admission and commitment of their child?

A. Generally, what I examine is the presenting problem of the child. At the same time, it is not possible to examine motives of the parents at all times.

Q. But sometimes?

A. It depends on an individual case, what the circumstances are involved.

Q. Didn't you state earlier, in answer to my question, that you did examine motives of the parents?

A. No, I interview parents.

Q. In that interview, as I think you answered earlier, you examine the motives of the parents?

MR. ROTH: Objection. She already (73) indicated she does not examine the motives as you have indicated. She indicated that she interviews the parents.

MR. FERLEGER: This record will speak for itself.

A. It's not the admission procedure to examine motives of applicants, but the admission procedure is to examine the needs of the child, based on the psychiatric problems the patient presents.

Q. One of the ways of doing that is by the information gotten from various informants.

MR. ROTH: Objection. It is misleading. You are saying information from sources other than the psychiatrist. From my understanding, it is Dr. Armstrong's testimony that the person is admitted based on the psychiatric evaluation of the child or juvenile in this case, as it is determined whether or not this juvenile needs to be admitted.

BY MR. FERLEGER:

Q. Dr. Armstrong, when parents apply to have their child admitted, the normal procedure is to speak also to the parents; is that so?

A. Yes.

(74) Q. And the parents talk to you?

A. Correct.



Q. Do they tell you things about their child?

A. Certainly.

Q. Those are things you consider in making your professional evaluation?

A. But it is—an attempt is continually made to base any admission or observation on historical data that's presented by the parents. It is not a specific examination of the motives behind the facts.

Q. The parents present you with historical data about the child and you try to evaluate that and find in it, whatever psychiatrically relevant things there are?

A. It is based on continual examination of the child. The data isn't taken at face value.

Q. Have you found a case where some or all of that historical data was incorrect or fallacious?

A. I would say any historical data is subject to the interpretation of the person presenting it.

Q. Have you found a case where the parents, in your opinion, intentionally gave false information about a child they were presenting?

A. I don't know how I would determine that.

(75) Q. Have you ever found that to be true, either later on through other conversations or through social work history records?

A. That's historical data related by parents which is fallacious in part?

Q. Yes.

A. I am sure that occurs. You are asking me for data I can't give you.

Q. In those instances where the information is fallacious or incorrect, the only way you have of checking that is by your asking the patient, or other individuals, or doing your own investigation?

MR. ROTH: Objection. It has already been indicated that when the child becomes a prospective patient at Haverford, that Haverford undergoes its own independent psychiatric examination.

BY MR. FERLEGER:

Q. (Continued) Okay. Can you answer the question?

A. You will have to repeat the question.

(The reporter read the pending question.)

A. Any investigation is made by the available data. The usual admission procedure is that we request any school records, neurological background, examinations, electroencephalograms, medical examinations, (76) preceding psychiatric evaluations, or other ancillary data be presented.

It is not the function of an admitting physician to be a private investigator or check out the total validity of each fact. This is usually when things are correlated with other data that's considered in the total evaluation, but the primary evaluation depends upon the presenting child and symptomatology.

Q. The presented child usually doesn't have a lawyer with him or her?

A. Correct.

Q. Do you interview the parents in or out of the presence of the child?

A. As you are familiar, there are multiple ways of conducting psychiatric examinations. Depending on the individuals background and preference, either the entire family can be interviewed together, the child and parents may be interviewed without other family members, the child may be interviewed individually, and the parents may be interviewed immediately.



Q. Are the parents under oath at that time?

A. No.

Q. Is the child under oath?

A. No.

(77) Q. When you interview the parents privately, is the child informed of the content of those conversations?

A. Certainly.

Q. In what way?

A. If the child is not present, then the usual procedure, at least at Adolescent Services at Haverford, is to ask the child if the child would like to remain present. If the child does not wish to do so, the contents of the interview are explained to the child.

Q. By whom?

A. The examining psychiatrist.

Q. So, in every case then where the parents are interviewed, the child can be present if she wants to, in your Service?

A. That's correct.

(A recess was taken at 12:00 o'clock.)

(The deposition reconvened at 12:10 p.m.)

BY MR. ABRAMSON:

Q. Dr. Armstrong, first I would want to ask you a specific question, in that what I would like to know is: since you have been at Haverford State Hospital, can you recall any incident in which you felt professionally that there was a juvenile at the hospital, for however short a period, who in your opinion, did not require (78) the facilities of the hospital for medical reasons?

A. I can answer that most specifically by stating: in the American Psychiatric Association's diagnostic manual, the diagnostic manual called a diagnosis incorrect as

based on the psychiatric factors found, and that diagnosis was given one child in four years, namely, Cheryl Ann Masagee, M-a-s-a-g-e-e.

However, in reviewing Cheryl's chart, she was placed in a hospital by a civil court commitment on a 406.

Q. With reference to this specific individual, may I ask how long she remained at Haverford State Hospital, not the specific number of days, but do you recall—

A. Approximately three months. To qualify that, it was necessary to: one, change custody of the child for her best interest from her mother who had pressed the court for the 406 commitment, to the child care agency of Delaware County, which needed a court hearing; and secondly, a suitable placement for her, in acting in her best interests, was required. The court proposed to place her in a juvenile detention home, which the Adolescent Service at Haverford State Hospital felt inadvisable, and the child did not wish. Subsequently, a foster home was found by the Legal Aid Vocational (79) Department and was accepted.

Q. Now, specifically with reference to the procedure at Haverford, when a young person at the time of admission is found to be in need of care or treatment under the Act, is it always possible for them to go directly to the juvenile building or Building 9; is it always possible for them to be immediately transferred to Building 9 for care and treatment?

A. The way the Adolescent Service is set up at this particular hospital, namely, Haverford State Hospital, the Adolescent Service operates both a closed service and an open service. The open services mentioned is at Building 9, and admission to the open service is contingent upon the child's ability to maintain adequate social behavior in an open setting.



Where the child is too ill or too impulsive and unable to contain their behavior, it is necessary that they be placed in the closed unit.

Q. In the event that a young person is found to be in a suitable state for the open unit, either at the initial admission procedure or following a period of time in the closed unit, will he immediately be transferred to the open unit, or is that contingent upon there being a vacancy in the open unit?

(80) MR. ROTH: I object to this line of questioning. I mean I don't understand the methodology of the admission and commission procedure attached in this case.

BY MR. FERLEGER:

Q. (Continued) Can I explain it, or is it clear what I am asking?

A. I believe I understand your question. I would like to, before I answer that, state two sentences which are not diverting from your question. The Adolescent Services as set up at Haverford is a service whereby admission to the service must be in accordance with certain criteria, and that includes some degree of order in the intellectual capacity for survival, in the open building. When their condition allows, they are transferred to the open setting.

Two, it is contingent upon the availability of the beds. However, the hospital administration has expanded the capacity for children a hundred percent in the past four or six months, so that in fact the requirement of waiting for a place is usually no more than approximately two to three days.

Q. Have you in your experience been confronted with a situation in which the young person was in the

(81) closed or locked building and it was felt that they were suitable for transfer to the open unit, but yet, this transfer was held up for more than the approximate period of two or three days because of non-availability of space for them?

A. Prior to the availability of the additional half of the building it was true, but again, as the general situation was, it was no more than the maximum of a week.

Q. Thank you. The next question is more of a general nature than a specific nature. Getting back to the admission procedure, when a patient comes in with their parent to the hospital, and at some point it becomes clear to the child he is being brought to the hospital to be evaluated, with the possibility they may be admitted to the hospital, do you feel professionally that the knowledge of their impending commitment or admission to the hospital may have an effect on the image, what they present to the admitting physician, or perhaps, on their mental state at the time of the admission procedure?

MR. ROTH: I object on the basis that this question has been asked before and answered before.

(82) A. It may. It would depend, as I answered before, on the degree of volition with which the child presents itself. If the child is willing to come, it's a positive effect. If the child is negative regarding admission, the knowledge may have an effect and it may not. There is no general situation that may be given.

Q. You mentioned there was a practice at Haverford State Hospital, I believe, where if the child was favorable to admission, that you often allow them to sign the formal papers, as well as their parents?



A. This is the practice of the Adolescent Service itself, and the child is requested to sign in all instances; and in my personal dealings, the child has so done.

Q. In all instances, as I understand you to say, this is where the child was favorable to admission?

A. Right.

Q. This question may seem rather basic, but do you feel that allowing them to sign themselves in is beneficial to—

A. It allows them to have responsibility over their subsequent fate. So, it is rather obvious—

Q. Responsibility over their subsequent fate?

A. In their admission.

(83) Q. In other words, so that they are on record as favoring it? Is that what you mean? Because I understand it wouldn't affect their release. The fact they signed initially would not require that they signed to be released?

A. If I can amplify the procedure of the Adolescent Service again: wherein a 403 voluntarily committed child, 18 or under, wishes to be released, they are so advised by our staff to write to the hospital director of their desire to leave, and within the 10 days subsequent, their parents are notified, either by the child, which is requested, or by the staff—and in all cases, by the staff—and a conference is held, and either the commitment is then recommended to be changed to a 406 or the child may be released. This is amplified in the present Mental Health and Retardation Act. Because, under the Act, it states that the applicant or someone acting on the applicant's behalf, must write to the hospital director—in this case, the child—and this gives them their constitutional right guaranteed them by law.

Q. If the applicant does not wish to consent in writing, solely by this fact, the child would not gain the release?

(84) A. Yes, it does not affect their release. It does in the Adolescent Service, however, in all instances that I can currently remember. There may be exceptions that have caused the social service to reflect their views, to change the commitment to a civil court commitment.

Q. But you don't know whether this procedure or other ones is followed in other facilities across the state?

A. I have no knowledge.

BY MR. ABRAMSON:

Q. With reference again to the admission procedure, in the event an admitting physician does not feel that the juvenile brought in by the parents is in need of care and treatment at the facility, is there anything, to your knowledge, to prevent the parents from then attempting to admit the child to another facility within the state?

A. No. To my knowledge, there is no legal machinery that protects the child. There is no central clearing agency that has all daily admissions and evaluations in a memory bank, so to speak.

(Discussion off the record.)

BY MR. FERLEGER:

Q. Do you have, Dr. Armstrong, all correspondence, books, records, and documents relating to placement (85) criteria of the Department of Public Welfare for admission or commitment of juveniles, as you were requested to bring?

A. I consulted with the hospital director regarding your request. Haverford State Hospital has no additional



records, documents, books, or correspondence relating to admission, other than the Mental Health Act itself.

Q. The Department of Public Welfare, do they have any other such records or documents?

MR. ROTH: I object to that. I don't think Dr. Armstrong can answer as to what they have. She can only answer for the institution she is employed by.

MR. FERLEGER: If she can't answer, she can tell us.

A. I don't know.

Q. Have you seen, Dr. Armstrong, the answers to the first set of interrogatories that were signed by Mr. Roth?

A. Yes, I have.

Q. Do you have them here?

A. Yes.

(The witness handed a document to Mr. Ferleger.)

(86) BY MR. FERLEGER:

Q. Now, in your experience at Havorford State Hospital, is it correct that the standards used for admission or commitment of juveniles and those standards used for adults are the same, namely, that they're based upon the Mental Health Act standards for the mentally disabled and in need of care and treatment?

A. I don't understand your question.

Q. I will rephrase it. What are the criteria for admission or commitment of juveniles to Haverford?

MR. ROTH: Objection. I am not certain I understand the question. Are you talking about a professional opinion, whether or not the child is in need of institutionalization, or the law itself?

MR. FERLEGER: I am asking what the criteria are.

MR. ROTH: With regard to what?

MR. FERLEGER: Admission or commitment of juveniles. You seem to—

MR. ROTH: I don't understand your question.

MR. FERLEGER: You seemed to understand it well enough in the interrogatories. I am (87) asking the same question you answered and gave your name to.

MR. ROTH: I would like the question clarified for the witness.

BY MR. FERLEGER:

Q. (Continued) Dr. Armstrong, what are the standards or criteria you used in an attempt of admitting—

MR. ROTH: Objection.

A. I would say—

MR. ROTH: I can object on behalf—

MR. FERLEGER: You can permit her to answer.

MR. ROTH: I am merely objecting on the basis of what I understand is the Mental Health and—

MR. FERLEGER: You are answering for her, and your objection is fine, but do not answer for her.

MR. ROTH: I am not answering for her.

A. The criteria are the same criteria as in the Mental Health and Retardation Act itself.



Q. Which are what?

A. I don't have to read the entire thing?

(88) Q. The criteria you used from the Mental Health and Retardation Act for admission or commitment of juveniles to a facility?

MR. ROTH: At this time, would you like to stipulate as to what section, 402 or Section 403 say, or would you have Dr. Armstrong read it into the record?

BY MR. FERLEGER:

Q. (Continued) Read into the record that portion which gives the standards and criteria, if they are used, for juveniles.

A. The entire listing of things which are under the mental disability statement, which are under Article 1.

Q. What section of that; what section of the Act?

MR. ROTH: I object first, on the basis I don't know where you are going with this line of questioning. I would like an offer of proof before we get into the Mental Health and Retardation Act of 1966.

BY MR. FERLEGER:

Q. (Continued) You are referring to Section 102, to the definition of mental disability; is that correct?

A. That's what I am referring to.

(89) Q. And if I understand you correctly, this gives the definition of who suffers from mental disability, as defined there, who would be eligible for commitment?

A. Correct.

Q. To your knowledge, that definition of mental disability is also used for admission or commitment of adults as well?

A. To my knowledge.

MR. FERLEGER: Dr. Armstrong and Mr. Roth, I think we have agreed previously that in order to dispense with the necessity of Dr. Armstrong having here all the medical charts of all juveniles who are presently patients at Haverford State Hospital and named plaintiffs, that plaintiffs' counsel will be permitted to examine the correspondence, book records, and documents at Haverford State Hospital. Do we agree, or do you want to add something?

MR. ROTH: My understanding is Mr. Ferleger has an agreement with Haverford State Hospital which grants him access to all the information that he has addressed himself to, and my direction would be that he would be allowed to review those records, and also, it (90) would be my understanding, as I hoped it was Mr. Ferleger's, that he would use those to the best interests of these patients.

MR. FERLEGER: No doubt about it. Just to clarify things, on Exhibit A, there are three individuals there whose names there are lines through.

THE WITNESS: They are for a 408 criminal court commitment, and in our desire to supply you with all necessary data, we overextended available information.

MR. FERLEGER: Our request did pertain to all juveniles.

THE WITNESS: Then you do want them.

MR. ROTH: Your request directs itself to voluntary admissions. Are you referring to No. 9 of interrogatories?



MR. FERLEGER: No. Our notice of deposition refers to all juveniles who are presently patients.

David Rhinehart, age 16; Elizabeth Schriber, age 14; and Stephen Willett, age 16.

MR. ROTH: As far as I am concerned, since you have access to the records and we have (91) addressed ourselves to that, you are permitted to review them according to those juveniles presently in the facility.

MR. FERLEGER: Your turn.

MR. ABRAMSON: May I ask one question?

BY MR. ABRAMSON:

Q. I wanted to ask: if a juvenile is a patient at the hospital under either Section 402 or 403, and a parent comes to the hospital and would like to withdraw the child from the hospital, and the hospital has no objection, does the hospital concern itself with the future disposition of the child?

A. Yes. That's a useful question, I think. The hospital and the psychiatric staff, the psychologist, the social service nurse, and the lab services are, as part of their agreement to offer services in the examination, care, and treatment of the child, are required to recommend outpatient treatment if there is indeed a recommendation.

In Haverford State Hospital's instance, the outpatient clinic has been discontinued, and therefore, outpatient care is referred to four base service units in Delaware County. In other instances, if private therapy can be arranged, that is recommended, in (92) addition to the Department of Family Therapy at Haverford State Hos-

pital. Haverford State Hospital has an agreement with those patients involved in family therapy to continue three months of outpatient treatment.

In all instances, if further treatment is recommended, specific recommendations are given to both the child and the parents. Where an additional agency is involved, such as the probation department, the probation officer is consulted prior to the child leaving, and reasonably, at least regarding the child's needs and the hospital's recommendations, requirements are set up. All liaison with any social agency is attempted to be implemented for the child's care, and are worked with and met with prior to discharge so that the child's care does not stop when the child is discharged.

BY MR. FERLEGER:

Q. If the parents want the child out—if he has given notice to withdraw the application and you feel the child needs inpatient care, then, as I understand your testimony today, there are two things that can happen to him: either the child would be permitted to sign against medical advice, or, in your judgment, might have to have some child care or other (93) agency press for court commitment?

A. That's correct.

Q. Of the people listed in Exhibit A, can you tell me if you know which persons are there as a result of your having to do—to ask for a court commitment when the parents wanted the child out?

A. When the parent wanted the child out?

Q. That's correct. Are there any people there?

A. There are none.

Q. So that doesn't happen very often, I guess?



A. I am sorry. There is a correction. Your question was—can you tell me your question again?

Q. Are there people listed on Exhibit A, with reference to whom the parents have asked the application be withdrawn, with reference to whom you have had to ask or have an agency ask the court for a 406 commitment?

MR. ROTH: Objection.

A. Never mind. You are focusing on whether the application is withdrawn?

Q. Yes.

A. You are asking me if there are any patients whom we have had to request the commitment be changed? You do understand the parents have a right to disagree with our request, and a child, where this occurred—(94) and the resolution of the case—Mary Lou Gallagher—against medical advice, because the parents refused to institute a 406.

Q. Could you institute a 406?

A. There is no way in which, at any time, the hospital can act in loco parentis with the parents' disagreement.

Q. Then what I stated before is incorrect; if the parents disagree with you, your only alternative is to have a child sign out against medical advice?

A. That's correct.

Q. The reason is, even though you personally administer psychiatric care, you are not in a position to apply to the court?

A. That's correct.

BY MR. ABRAMSON:

Q. Doctor, is it also true with reference to recommendations you indicated are often made following dis-

charge of a patient, when you make certain recommendations to parents for continued care or whatever you mentioned previously, again, the hospital has no machinery in which to expel the complaints?

A. No. However, it should be noted, our major emphasis is dealing with the child, and with the (95) exception of a very small percentage, the children themselves, once they are worked with, are advised of their need for treatment and they are given the available base service unit address, phone number, et cetera, so they themselves may seek out their treatment, regardless of their parents' desires.

Q. But if a patient, a juvenile, changes his or her mind, you don't have authority to expel him or her?

A. No. The probation office does. We do not.

MR. FERLEGER: If the child happens to be under probation.

No more questions.

Your turn.

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*Cross-Examination*

BY MR. ROTH:

Q. Dr. Armstrong, let's take a hypothetical situation and follow it through. If a parent wishes to admit a child to your institution under Section 402 or Section 403 of the Mental Health and Retardation Act, what is the first procedure which you utilize?

MR. FERLEGER: Objection. We went through this before, and you objected.

MR. ROTH: That is not true.



(96) BY MR. ROTH:

Q. (Continued) What is the procedure you utilize?

A. The parent is referred to a designated social worker of the Adolescent Service, and what is stated as an in-take interview is arranged with the parents, is one instance. On other occasions and more frequently, the entire family is given an appointment and a joint interview with a psychiatrist and social worker is held to determine whether or not the child requires admission and care.

Q. From what you have indicated in your examination by Mr. Ferleger and Mr. Abramson, it appears that if a child is admitted, or applied for admission other than by his parents, then you make a psychiatric examination. Do you, at that time, determine, based upon your examination, whether the best interests of this child are going to be served by institutionalization?

A. (No response)

Q. In other words, do you determine that the child needs institutionalization, based on an independent psychiatric examination?

A. Certainly.

Q. Now, if this child does not need institutionalization, do you still institutionalize him?

(97) A. No.

Q. If the parents, for any motive other than the best interests of the child, try to petition for his admission into the institution, do you, nonetheless, still conduct an independent psychiatric examination to determine whether or not this child needs institutionalization?

A. Yes.

MR. FERLEGER: Do I understand you to be inquiring into the motives—whether Dr. Armstrong

inquires into the motives or reasons of the parents' interests in committing the child?

MR. ROTH: According to the rules of the court, I am completely within the realm of the examination placed upon the witness before.

MR. FERLEGER: I have to ask you to clarify the question in order to determine whether or not an objection is necessary.

Do I understand you to be asking Dr. Armstrong if she inquired into the motives of the parents, and as a result of that, if the motives are improper, she determines not to institutionalize the child?

(98) MR. ROTH: I will repeat my question for you, if you will listen carefully.

BY MR. ROTH:

Q. (Continued) Notwithstanding the parents' reasons for appliance for admission for their child, does the institution conduct an independent examination in order to determine if a child is in need of institution care?

A. Certainly. In all instances, I would say an examination of the child is made.

Q. Let's say the child is admitted to the institution. After the child is admitted to the institution, and without getting into what kind of care or treatment is provided by your institution, in the event that the child is deemed to be sufficiently capable, in accordance with whatever medical or professional terms you used, what do you do? Do you recommend to the parents, his release? What procedures do you utilize then?

A. Repeat that.



Q. For example, after somebody has been admitted, and because of your care and treatment, is now sufficiently capable to return to society and eventually, to the family home, what do you do at that time?

A. We recommend to the child that his discharge be (99) effected, and we notify the parents of the same.

Q. Usually, when you do that, do the parents comply with you?

A. Yes, usually.

Q. In the event that the parent wishes to release his child from your institution, can you, at that time, indicate to the parent whether or not it is in the best interests of the child for him or her to be released?

A. Yes.

Q. Do you have instances where the child can be released, notwithstanding, medically, that it would not be in the best interests of the child to be released?

A. Certainly.

Q. If a child who is in the institution, objects to being institutionalized, do you follow that objection up at all with talking with anyone about it?

A. Certainly. The child is, as previously stated, advised by the entire staff to write a letter to the hospital director, Dr. Jack B. Kremens, and state that he wishes to leave the hospital. At such time, he is informed that he must inform his parents, and the staff also does. The staff, if the child is in need of further hospitalization, recommends the child's commitment, in 10 days as specified by law, be changed (100) to a civil court commitment, a 406. If the parents comply, this is done. If a parent does not, then the child is discharged.

Q. The summaries which you prepared today, on who were admitted, to wit, Exhibit B, were they—I believe—were the contents supplied in terms of requests,

on those summaries, which you discussed with opposing counsel?

A. Yes, they were, on an unofficial basis. Mr. Abramson has functioned as an unofficial advisor from Mr. Ferleger's staff for the Adolescent Service, and specifically, the Service's social worker, who made this form up for purposes of this deposition, and checked with Mr. Abramson as to its relevancy and completeness.

Q. Dr. Armstrong, questions have been asked of you with regard to examination, its length of time, under 406, as well as under 402 and 403. Is it your professional opinion that notwithstanding the procedures under which an applicant or court committed person comes into your institution, a substantial examination is carried out in order to determine whether or not this juvenile in this case needs institutionalizing?

A. Yes. I would add to my previous testimony, that (101) in this hospital's administrative procedure, there is an initial examination made by the psychiatrist, and is so designated as an admission note on the hospital record. Subsequently, for all adolescents on the Adolescent Service at Haverford State Hospital, there are routine studies done, such as an electroencephalogram, a neurological examination, a medical examination, and a complete battery of psychological tests and school evaluation, as well as a psychiatric evaluation. When all their data has been compiled, an entire staff conference is held, which is called a new case conference, at which point the complete case is re-examined and it is decided whether or not the child needs hospitalization, and at that same time, as well, an adequate treatment course is planned.

Q. Are periodic reports made and revealed to the patient and the parents for the basis of his continued need to be institutionalized?



MR. FERLEGER: I object. That is true of every hospital. That is standard and a required psychiatric practice that I don't think any institution in the State of Pennsylvania would say it doesn't follow. I would be horrified, and so would the doctor, if they (102) didn't continually work with the child and tell the patient what was happening.

BY MR. ROTH:

Q. (Continued) Would you answer the question, please?

A. Insofar as notifying the patient and his parents, or the applicant if it is not the parents, of the patient's status, the social worker is designated every 30 days to notify all admissions, regardless of types, of their status.

The parent or parents, or guardian, are met with, generally, weekly in some cases, to discuss the case. There is some social work counseling done in family therapy, and there are administrative parents conferences, the minimum of which are held once a month.

Additionally, as far as the patients' status and progress is concerned, in the Adolescent Service, there is a detailed progress report compiled by the Department of Research and Planning, in conjunction with Dr. Aaron Smith, wherein the patient's status is noted daily.

Q. Dr. Armstrong, you can correct me if I am wrong: one of the questions about the distinction between adult and juvenile was your admission procedure. Was your (103) answer that children by and large are unable to exercise judgment in determining whether or not they need care?

A. I would have to answer that question the same as I previously answered: yes and no. Some children are

able to exercise adequate judgment, depending on the nature and severity of their psychiatric condition, and their reasons thereof. To others, they are incapable. Their judgment is rendered non-functional by the basis of severe psychiatric problems.

Q. Dr. Armstrong, would it be your professional opinion that it is because the child, in particular, juveniles who are unemancipated—by that I mean living with their parents—could best be observed by their parents who can indicate to you that the child does need additional treatment or treatment per se?

MR. FERLEGER: Objection. Not only does Dr. Armstrong not know the legal definition of unemancipated, but your definition: someone living with his parents, is incorrect under the law of Pennsylvania. Under the law of Pennsylvania, a child can be living at home and still be emancipated.

Dr. Armstrong may know, because I wrote a letter, a legal opinion letter, with reference (104) to Trevor Haviland at the hospital, whether the child is emancipated and whether their family knows what this means legally.

I think that makes that question improbable.

BY MR. ROTH:

Q. (Continued) Let me rephrase the question.

In an environment where you have parents and a child living together, would you feel it is appropriate because of the relationship, because of the continual interaction among those people, for the parents to be best apprised in order to indicate to you or the institution that their child be in need of institutionalization?



A. I would have to answer that question as I did previously: yes and no. It would depend on the degree of stability and absence of mental disability, and the degree of maturity of the parents, the relationship of the child and the parents, and again, multitudinous other facts. In some cases, they would be the best observers, where the interaction is positive, and where the interaction is negative, they would not be.

Q. If parents would attempt to admit their child and your institution felt the admission was (105) inappropriate, your institution would not admit the child; is that correct?

A. That's correct.

Q. By and large, Dr. Armstrong, are most of the juveniles admitted or committed to your institution done so voluntarily by the child?

A. That requires the same estimate that Mr. Ferleger asked previously. Some are and some are not. To give you a figure, if you wish, I could count them from this list.

Q. Fine. Again, I am directing this question to the admission from the very outset, and not to subsequent development.

A. If the child requested admission; is that right?

Q. I am asking whether the child objected to his being admitted.

MR. FERLEGER: Go over each name and say—

MR. ROTH: No, I object to that.

BY MR. ROTH:

Q. (Continued) You do it on the whole basis. Say how many for and how many against.

(Discussion off the record.)

A. I think I need to qualify it. Do you mean (106) objected as far as I know at the time of admission, or objected at any time?

Q. Admission. I am also confining this to 402 and 403 commitments.

A. All right. Then those that did not object at all—

Q. Just strictly from admission.

A. Which must exclude six of the children on this list who are severely mentally retarded and cannot be considered competent—there are nine.

MR. FERLEGER: Who did not or did?

THE WITNESS: Who did not object—of 403?

MR. FERLEGER: And 402 is?

THE WITNESS: Okay. That is—

BY MR. ROTH:

Q. How many objected?

MR. FERLEGER: I think it is clear that if nine did not object, the rest objected, except for the retarded.

THE WITNESS: No, because in addition, some are severely psychotic and objection has no reference.

BY MR. ROTH:

Q. (Continued) If I understand, you are indicating (107) nine did not object, and that six were severely retarded, and some of the remainder are not able to exercise judgment in order to object and not object?

A. That's correct.

Q. And you indicated, such as Steve Gentile; is that correct?

A. For example, yes.



Q. Let me ask you this. As far as the named individuals in this particular lawsuit, could you tell me if they are currently in the institution?

MR. ABRAMSON: She has to answer your other question for us.

A. Just a moment. First of all, I am going to correct the first number. Speaking of those admissions, there are 16 that did not object at the time of admission. There are eight that objected, and the remainder are not competent, are severely retarded or psychotic, and cannot make an adequate judgment.

Q. Now, of those who objected at admission, what, if you will, deference did you give to their objection? How do you cope with an objection?

A. Well, it depends on individual instances again. If they are under a 406 or 408 as three were—

Q. So, three of the six who objected were under 408 (108) or 406?

A. That's correct.

Q. Court commitment? Some of the remainder of the remaining—

(Discussion off the record.)

BY MR. ROTH:

Q. (Continued) For clarification of the record, what you have indicated is 16 did not object, eight objected, and of the eight who objected, three came under the court committed procedure, with regard to Section 408 or Section 406; is that correct?

A. That's correct.

Q. Some of the remainder of those who objected were under 402 or 403, and there would be five?

A. Correct.

Q. Could you tell us what deference you gave to objections of those committed under 402 or 403?

A. They were advised to write to the hospital director of their desire to leave. We thoroughly researched their charts. It must be noted that on my list, only one of Mr. Ferleger's plaintiffs remains. However, of this list, none so instituted the writing of a letter to the hospital director, so there was no formal action taken by them, even though they had been (109) advised of the proper action to institute their discharge.

Q. Of those five, Dr. Armstrong, who objected, did you also notify their parents that they were objecting?

A. No, we did not. In this same procedure, if they would have written to the hospital director, the parents would be told at the weekly parent conference. They were not notified by a specific phone call. Had they initiated the writing of a letter to the hospital director—

Q. But the parents subsequently were notified?

A. Correct.

Q. Of the named plaintiffs in this case, how many remain in Haverford State Hospital?

A. None remain, however, Kevin Bartley is continued on short-term leave, as previously explained, for administrative purposes only. This allows him to procure transportation from both Delaware County and Chester County to attend Delaware County's intermediate special adolescent school.

Q. Do you know—

MR. FERLEGER: Is Kevin Bartley the only person on any sort of leave, and are the other people discharged?

(110) THE WITNESS: They are.



BY MR. ROTH:

Q. (Continued) According to your personal knowledge, do you know when those children objected, who are being represented by opposing counsel, whether opposing counsel proceeded to process any writs of habeas corpus to have these people released?

MR. FERLEGER: Objection. That doesn't have any relevance to either this proceeding or the court.

A. To my knowledge, they were filed.

Q. Dr. Armstrong, I just want to emphasize again: does your institution hospitalize anyone who does not require hospitalization?

MR. FERLEGER: Objection. That is repetitious of two of your questions and five of mine.

A. I cannot answer for anyone, Mr. Roth, as I previously stated. By experience at this institution as director of the Adolescent Service and my experience, of which 99 percent is with juveniles, I may say, on rare occasions I will do a professional colleague a favor and do his duty, which may require my admitting an adult. Very rarely under those circumstances do I (111) encounter an adult admitting their requiring admission.

Q. I gather from what you said, if your institution feels that a child no longer is in need of institutionalization, that you effect the proper procedure in order to have that child discharged or released; is that correct?

A. That's correct.

(Discussion off the record.)

BY MR. ROTH:

Q. Dr. Armstrong, in your professional opinion, do you feel that anyone, be it juvenile or adult—and this is

general—could best be evaluated by a psychiatrist, as your institution has, and by that procedure implemented, to determine whether or not that person needs institutionalization?

MR. FERLEGER: Objection. What do you mean by "best"?

BY MR. ROTH:

Q. (Continued) Could be evaluated by your institution in order to determine whether or not this person needs institutionalization?

A. Could you repeat that?

MR. FERLEGER: Objection. I think you are misleading the witness.

(112) BY MR. ROTH:

Q. In other words, what I am asking you is if any persons had wanted to be admitted to your institution—and I believe we are all well enough aware that we are now going into the realm of medical, professional, psychiatry evaluation—would it be your opinion that your institution could do this and does it?

MR. FERLEGER: Objection. The law is quite clear. Despite the requirements of the institution, a person cannot be committed solely on sight recommendations of any number of doctors. So, the fact that Dr. Armstrong thinks that—

MR. ROTH: I am merely asking her in her professional opinion.

MR. FERLEGER: Whether Dr. Armstrong feels that a doctor should have authority to evaluate and sign people into hospitals, in reference to adults in this state, it is quite clear that doctors do not have that authority.



BY MR. ROTH:

Q. (Continued) Can you answer that question without referring to any legal procedures, which Mr. Ferleger has led you to believe are incorrect?

MR. FERLEGER: I mean you are trying to (113) limit her answer.

BY MR. ROTH:

Q. (Continued) Can you answer my question, please?

A. Can you repeat the question again?

Q. From what I see, your institution, notwithstanding the voluntary admission, can make an independent determination to preclude admitting some patients?

A. That's correct.

Q. By the same token, can your institution make an independent determination to ascertain whether a person needs institutional care?

A. The institution does so by examination. The psychiatrist can, as I understand the present law, recommend hospitalization. They cannot institute it.

Q. Fine. But your institution can preclude the admission of someone under 402 or 403 if it feels that person does not need to be institutionalized?

A. That's correct.

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*Redirect Examination*

BY MR. FERLEGER:

Q. What are the names of the persons in Exhibit A who objected to hospitalization? You referred to the number originally as eight in response to Mr. Roth.

(114) A. I want to make it clear that you are asking me for my professional opinion, which is based on memory, and it may well be that you will not find evidence of this in any record. However, in your questioning, you did not confine yourself to written facts, so I am giving my opinion.

One is Kevin Bartley; two is John Cross; three is Michael King; four is Ben Mosco; five is Thomas Hockenberry—we are including No. 405?

Q. Yes.

A. Graber, James.

And we are including 408; right?

Q. Yes.

A. Elizabeth Schriber.

Q. How about Rhinehart?

A. He preferred to come rather than go to jail.

Richard Burns; Anita Jenkins; Stephen Willett.

MR. ROTH: That's all?

THE WITNESS: That's the best I can do.

BY MR. FERLEGER:

Q. By my count, the number of names you have is 10 who objected.

A. You may be right.

Q. Of the remaining people, how many of them objected (115) to being hospitalized during the time of their hospitalization at any time during the time of their hospitalization?

A. We are using the definition of objected, as I have heard them object?

Q. Or you know from your associates that he objected or gave written notice?

A. None have given written notice.



Q. Of these other people.

A. None on the entire list.

Q. And how about in any way to staff members?

A. I have to add, insofar as my knowledge, it's incomplete.

What are you going to do about competent and incompetent people?

Q. If they have objected, then say so. Then say objected, but incompetent people. If they are incompetent, why don't you say—

A. I will run down the entire list.

Q. Except for the ten people you just mentioned.

A. Timothy Baer, objected, not competent.

MR. ROTH: You also included Timothy Baer as one of the 10, didn't you?

THE WITNESS: No, Bartley.

(116) A. (Continued) Mary Lou Gallagher.

Q. What about Suzanne Garrelli?

A. She came voluntarily.

Mary Lou Gallagher objected and signed out against medical advice, which I previously stated.

Stephen Gentile, not competent.

Pollock, Michael, objected and obtained his own court hearing. He is under 406.

Do you want the resolution of that?

Q. No.

A. Okay. David Rhinehart objected.

Michael Vantine objected.

David Parmet is not competent.

William Cutilli is not competent.

Thomas Taylor objects.

Peggy Ann Saunders is retarded, minimally competent, no objection.

Walter Lucas is not competent.

MR. ROTH: Had Walter Lucas objected?

THE WITNESS: Not to my knowledge. They are part of the Adolescent Service.

BY MR. FERLEGER:

Q. The others what?

A. In this list are even a number of children who (117) were not accepted into the Adolescent Service by virtue of either being too severely brain damaged or too retarded to participate in the program.

Q. Doctor, with reference to being accepted into your program or not being part of your program—

A. By virtue of present retardation, they are considered not competent.

Q. Which are they?

A. Walter Lucas.

Q. Point No. 2, you stated that the social worker, every 30 days, gives notice to the juveniles that are there under 402 or 403 commitment. In what way do they give that notice?

A. They verbally inform both the child and the parents. Either the parents are notified by telephone or informed by the weekly conferences.

Q. Is the fact that this information has been given to parents noted on the medical charts?

A. No, it is part of the routine procedure. However, in checking with the social service department, since the papers of a 403 are to be resigned every 30 days, the resigning itself is sufficient notification and, therefore, no notation is made.



Q. What is the notification of parents?

(118) A. That the child is notified verbally.

Q. Dr. Armstrong, two or three months ago, David Purcell of your staff kindly invited me to come to one of your staff meetings, and at that meeting, certain procedures happened, and I would like to describe it for you and ask you whether that procedure of your staff is typical. This follows with reference to what Mr. Roth asked you about.

A patient had given a letter to the staff, expressing his desire and intention, if permitted, to leave. This matter was brought before the staff members as an assembled staff of psychiatric aides, doctors, and there was a discussion by the staff of the person's history and progress, and there was a discussion about the person's family situation. Then, there was a consensus agreement that the person was not yet ready to leave the hospital, and the staff member who received the letter was instructed to tell the patient that right now, he can't leave.

Is that the normal procedure?

MR. ROTH: I object. First of all, you are doing the testifying about a conference which we haven't established whether Dr. Armstrong was part of.

(119) Secondly, if you want to testify, we can put you on the stand.

Thirdly, as far as the information goes, as far as I can gather, is strictly hearsay, and based on only part.

Now, if you want to ask Dr. Armstrong about the procedure that is utilized, you may do so.

MR. FERLEGER: Your objection is noted.

BY MR. FERLEGER:

Q. (Continued) Is that procedure that which is typically followed?

A. I think, as I previously stated, Mr. Ferleger, in dealing with children, particularly disturbed children which we are speaking of, one cannot have a typical procedure. There are general cases, but actually, there are many exceptions as well.

Q. The procedure I described, is that one which—

MR. ROTH: I object to that question, and again, because there has been no foundation laid appropriately in order—

MR. FERLEGER: Depositions don't require foundations.

MR. ROTH: We are questioning and (120) cross-examining Dr. Armstrong according to law, and accordingly I advise you with regard to questions and answers that may be asked, if the proper foundation is not laid for a question then it obviously is of no matter whatsoever. If you want to ask about the procedures, fine. If you want to ask Dr. Armstrong to be a little more help to you, you can ask if she is aware of this particular meeting, according to her personal knowledge. I do not want you to mislead her since I do not know for a fact that the actual situation which you allegedly stated has occurred, and asking her whether that procedure is a uniform procedure is questionable. I have no basis of knowing the validity of that conference per se.

BY MR. FERLEGER:

Q. (Continued) Dr. Armstrong, assuming hypothetically the procedure I described happened as I described it, is that one of the procedures for dealing with such a notice, that your staff follows?



A. Is it one of the procedures?

Q. Yes.

A. Hypothetically, okay.

(121) Q. Assuming the facts I stated are correct, is that one of the procedures that your staff follows?

A. That's one of the procedures. There is, however, and I would prefer to elaborate for you, an additional and more useful one, which is in accordance with our major purpose of being here, and that is what regards the child's best interest. As you are well aware, any effective treatment service is continually re-evaluated and reformulated. The therapeutic community has a general meeting wherein persons requesting those passes for brief periods of time and discharges are brought up. The patients themselves—the patient's consensus is noted for the central community, who then meet with the Adolescent Service and the staff gives their opinion. It is to be noted that the staff may agree to the patient's recommendation, however, in general, a consensus agreement is attempted to be made. So that is the most general procedure than the one you stated.

Q. What if the professional staff feel it is not in the best medical interests and the—

A. I would disagree with you: medical interests. I would say the best interests of the child.

Q. If the professional judgment about the best interest of the child conflicts with the community's (122) recommendations, then you would feel obliged to agree to that suggestion?

A. That's the truth. However, to date, that has not happened.

(Discussion off the record.)

BY MR. ABRAMSON:

Q. With reference to Mr. Roth's question concerning the follow-up—all of the procedures which take place while a young person is at Haverford, I notice in particular, with reference to Miss Vicki Mathews, in the summary prepared for her, there is reference made to this continual evaluation and coordinated efforts. In particular, I notice reference is made to the recommendation concerning Devereux School for this patient.

A. Yes.

Q. And my question is—I don't see it here on this summary—do you recall if the patient, Vicki Mathews, expressed any feelings as to her opinion of Devereux School being a boarding school?

A. Yes, I recall, specifically, Vicki Mathews' opinion. Victoria Mathews is one of the patients that fits the category of being non-volitional on occasions, and on other occasions she would admit to myself and Dr. Rosen that she had problems, and on other occasions, (123) she had not, and therefore, resisted any additional psychiatric care. As you can see by her record, she had been through both Irving Schwartz Institute and the Philadelphia Child Guidance Clinic before she reached us. This is a particularly difficult individual to handle, so that the recommendation for a private facility was made more on the basis of this being something that the patient and her family could accept, rather than feeling that our facility was incapable of handling her.



BY MR. FERLEGER:

Q. Where is Devereux School?

A. Devereux School is a multitude of schools. The main office is in Devon.

Q. Is it in Pennsylvania?

A. One is in Pennsylvania. One is in Massachusetts. One is in Connecticut, and one is in California, and one is in Texas.

Q. Do you know which branch Vicki is in?

A. Yes. As general director and director of that Adolescent Service of which we speak, it becomes necessary to deal with directors of similar residential settings.

Q. Can you tell me?

(124) A. Their recommendation was that she go to Texas, and that is indeed where she went.

Q. Do you know what town?

A. Victoria.

Q. Would you call Vicki Mathews a non-volitional patient?

A. At times.

Q. Is Mark Weand a non-volitional patient?

A. At times.

Q. And what about Leslie Levine?

A. At times.

Q. And Kevin Bartley?

A. At times.

Q. And what about Steve Gentile?

A. He was Dr. Hammer's patient, and his opinion is that he was severely psychotic and not competent to exercise judgment, and my comment is I feel his objection is one that you cannot take heed to. His objection is not realistic.

Q. Do I understand that he has made objections, but because of the medical factors you mentioned, you don't feel they have substance?

A. That's correct.

MR. FERLEGER: I have no further (125) questions.

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*Recross-Examination*

BY MR. ROTH:

Q. Dr. Armstrong, now, we have been talking about objections, and I only have one question with regard to these objections. What is the nature of these objections? Are some of them inconsistent one day or they are objecting the next day, or complaining, or are they up and down, if you will, like a yo-yo, objecting one day, and something where they are objecting the next day? Do you have an instance of this sort with regard to that type of objection? Are these types of objections consistent and repeated?

A. Yes and no. Some indeed are reflections of the child's ambivalence toward their illness, such as Kevin Bartley, and Vicki Mathews, and Mark Weand. One day they feel they can handle the problems themselves. Then when confronted with their own behavior, such as Mr. Weand's drug taking or Miss Mathew's suicide gestures, such as lacerating their wrists, their behavior is difficult to deny and the patient acknowledges the presence of his problems and has some psychiatric difficulty. In other instances such as the case of (126) Mr. Burns, who is in under 406, his diagnosis is that of personality disorder. Without going into the nature of such a diagnosis, it allows for consistent repetitive resistance toward any communication and resistance toward being hospitalized.



Q. Dr. Armstrong, with regard to the number of individuals that you have in your institution, is your specific program running at full capacity?

A. Almost full capacity.

Q. Is there a great turnover in terms of your institution wishing to release juveniles once they have attained their prospective or whatever professional terms you utilize?

MR. FERLEGER: Objection. A great turnover with regard to the institution's desires?

BY MR. ROTH:

Q. (Continued) I said: a great turnover in the number of patients, juveniles.

A. Again, I would have to answer you that with Dr. Smith's research department, we are in the process of compiling adequate statistical data which I haven't currently been able to get compiled. I can't give you figures of our average length of stay or discharge and admission rate. All I can tell you is that some patients (127) stay for two or three weeks. Some stay for several months. Their lengths of stay are based on their need for hospitalization.

BY MR. FERLEGER:

Q. In the ambivalence toward hospitalization, asking to leave one day or objecting one day, and not the next, that is true of adults as well, isn't it?

MR. ROTH: Objection.

A. Some, I would say.

Q. Is it true of some adults?

A. Yes. One cannot generalize about any statement regarding the psychiatric status of one individual.

Q. It is true of some adults and some juveniles?

BY MR. ROTH:

Q. With regard to ambivalence, is ambivalence precipitated by the condition of the patient?

A. Yes.

MR. ROTH: Thank you.

MR. FERLEGER: I have nothing else.

(Witness excused.)

(Oral examination concluded)

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(128)

CERTIFICATION

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I hereby certify that the proceedings and evidence are contained fully and accurately in the notes taken by me on the oral examination in the above cause, and that this copy is a correct transcript of the same.

Patricia M. Kosmalski

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I have read the foregoing transcript of testimony given by me in the above matter, and hereby certify that it is true and correct to the best of my knowledge and belief.

---

Witness' signature



(129)

EXHIBIT A

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CLASS ACTION SUIT

| *Name* | *Age* | *Commitment* | *Assigned* |
|---|---|---|---|
| Bartley, Kevin | 16 | 403 | Dr. Armstrong |
| Baer, Tim | 17 | 406 | Dr. Rosen |
| Cross, John | 17 | 403 | Dr. Rosen |
| Carrelli, Suzanne | 16 | 403 | Dr. Armstrong |
| Clark, Beatrice | 13 | 403 | Dr. Lustig |
| Geiger, Deborah | 16 | 403 | Dr. Kratsa |
| King, Michael | 14 | 403 | Dr. Rosen |
| Edwards, Elizabeth | 15 | 403 | Dr. Armstrong |
| Gallagher, Mary Lou | 15 | 403 | Mrs. Parrish |
| Gentile | 17 | | Dr. Hammer, Ellen, [Illegible] |
| Golden, Sally | 14 | 403 | Dr. Armstrong |
| Hutchins, Judy | 17 | 403 | Dr. Lustig |
| McCauley, Mary Ellen | 16 | 403 | Dr. Armstrong |
| Pollock, Nick | 17 | 406 | Dr. Armstrong, Bob Schoenhultz |
| Mosco, Ben | 16 | 403 | Dr. Hammer, David Brosell |
| Hockenberry, Tom | 15 | 403 | Dr. Hammer, Kathy Olsen |
| Thompson, Terry | 18.9 | 403 | Dr. Lawson |
| Brehm, Nancy | 18 | 403 | Dr. Armstrong |
| Moss, Allen | 16 | 403 | Dr. Kratsa, Kathy Olsen |
| Graber, James | 17 | 405 | Dr. Kratsa, David Brosell |

| Name | Age | Commitment | Assigned |
|---|---|---|---|
| Rhinehart, David | 16 | 408 | Dr. Kratsa |
| Schriber, Elizabeth | 14 | 408 | Dr. Kratsa |
| Burns, Richard | 17 | 406 | Dr. Lustig, Bob Schoenhultz |
| Barnett, Willard | 15 | 403 | Dr. Kratsa |
| Vantine, Michael | 15 | 403 | Dr. Hammer |
| Osbourne, Sue | 16 | 403 | |
| Parmet, David | 16 | 403 | |
| Cutilli, William | 17 | 403 | |
| Jenkins, Anita | 16 | 408 | Dr. Wochiehowski |
| (130) Willett, Stephen | 16 | 408 | Dr. Kratsa |
| Taylor, Thomas | 14 | 403 | Dr. Lustig |
| Saunders, Peggy Ann | 17 | 403 | Dr. Rosen |
| Lucas, Walter | 18.5 | 403 | |



(131)

## EXHIBIT B

NAME: Baer, Timothy

AGE ON ADMISSION: 14 BIRTHDATE:

COMMITMENT: 1. Date on original and present: 5/15/69

2. Type on original and present: 404

3. Changes type and when: 10/16/72 406

ADMISSION: 1. Admitting Physician: Fong

2. Reasons for Admission: Homocidal & suicidal ideation. Hallucinating, phobic Ron-Rual

3. Who reported behavior: Family

DIAGNOSIS: 1. Admission Note: Schiz. childhood type

2. New Case Conference Note: Childhood schiz.

3. Discharge and date: Still in

4. Present:

PROGRESS: (Very brief summary of hospital courses; where admitted; doctor; what program; current status)

Long, stormy Hospit., mainly on closed wards; with multiple somatic complaints, physical attacks on staff, self-destructive behavior.

Presently on closed wd, on grounds, priv

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(132)

K.O.

2-21-73

NAME: Barnett, Willard, 14-6

AGE ON ADMISSION: 14 BIRTHDATE: 8-18-58

COMMITMENT: 1. Date on original and present: 1-8-73

2. Type on original and present: 403

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Dr. Armstrong

2. Reasons for Admission: 3 wks. of truancy; 3 days of uncontrollable behavior; threatened suicide

3. Who reported behavior: Mother

DIAGNOSIS: 1. Admission Note: Schizophrenia, simple

2. New Case Conference Note: None

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Dr. Kratza is his doctor.

Will had been transfered to Bldg. 9 once before, but apparently was not ready for an open unit & was transfered back to Bld. 4 On 2-20-73 he was transfered back to Blu. 9.

He is involved in O.T., A.T., RT & 2 group Tx.

---

(133)
KO
DATE: 2-22-73

NAME: KEVIN BARTLEY

AGE ON ADMISSION: 15 BIRTHDATE: 11-4-56 PRESENT AGE: 16-3

COMMITMENT: 1. Date on original and present: 11-30-71

2. Type on original and present: 403

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Dr. Ivins



2. Reasons for Admission: Transfer from ESSH, temper outbursts, difficult to control

3. Who reported behavior: Mother

DIAGNOSIS: 1. Admission Note: Organic Brain Syndrome with epilepsy. Personality disorder: explosive personality

2. New Case Conference Note: Explosive personality disorder with epilepsy.

3. Discharge and date

4. Present: On Short Term Leave since 11/23/74

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status.)

Kevin is on short term leave, attending the school program on the Hospital grounds.

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(134)
2/15/73

NAME: Burns, Richard

AGE ON ADMISSION: 17 BIRTHDATE: 12/18/55

COMMITMENT: 1. Date on original and present: 1/29/73; 2/2/73

2. Type on original and present: 406; 406

3. Changes-type and when:

ADMISSION: 1. Admitting Physician: Streker

2. Reasons for Admission: drug abuse & incorrigibility

3. Who reported behavior: Mother

DIAGNOSIS: 1. Admission Note: adjustment reaction of adolescence

2. New Case Conference Note: same.

3. Discharge and date

4. Present: unsocialized aggressive reaction of adolescence 308.4

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Admitted to Bldg 9 for evaluation. Assigned to Dr. Lustig. Individual & family sessions. No medications. Evaluation continuing.

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(135)
K.O.
2-21-73

NAME: Brehm, Nancy

AGE ON ADMISSION: 17 BIRTHDATE: 1-12-55

COMMITMENT: 1. Date on original and present: 8-9-72

2. Type on original and present: 403

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Dr. Armstrong

2. Reasons for Admission: Pt excluded from mothers home; previous drug use; previous admission to this hospital

3. Who reported behavior: Pt

DIAGNOSIS: 1. Admission Note: Adolescent adjustment Rx

2. New Case Conference Note

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)



Nancy is currently enrolled in the drug program on 1 No. Dr. Zal is her doctor. She is in the school program.

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(136)
K.O.
Date: 2-22-73

NAME: Carrelli, Suzanne

AGE ON ADMISSION: 16 BIRTHDATE: 4-16-56 Present Age: 16.10

COMMITMENT: 1. Date on original and present: 11-10-72

2. Type on original and present: 403

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Dr. Felix

2. Reasons for Admission: Suicidal ideation; chaotic family; has

3. Who reported behavior: Pt

DIAGNOSIS: 1. Admission Note: Schizophrenia, simple type with depressive features

2. New Case Conference Note

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Sue is a pt of Dr. Armstrong in Bld. 9. She is involved in the school program, and has group therapy 2 times a week. She goes home on weekends.

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(137)
Date: 2/15/73

NAME: Clark, Beatrice

AGE ON ADMISSION: 13 BIRTHDATE: 4/27/59 Present Age: 13

COMMITMENT: 1. Date on original and present: 1/16/73

2. Type on original and present: 403

3. Changes type and when: None

ADMISSION: 1. Admitting Physician: Armstrong

2. Reasons for Admission: episodic drinking, running away, & stealing "catatonia"

3. Who reported behavior: Mother & BSU psychologist

DIAGNOSIS: 1. Admission Note: deferred

2. New Case Conference Note: 308.4

Discharge and date

4. Present: unsocialized aggressive reaction of adolescence 308.4

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Admitted to Bldg 9, assigned to Dr. Lustig. Receiving milieu therapy & family therapy. Discharge anticipated soon.

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(138)

NAME: Cross John

AGE ON ADMISSION: 17y-o- BIRTHDATE: 10/9/54

COMMITMENT: 1. Date on original and present: 2/19/72

2. Type on original and present: 403

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Wicoff

2. Reasons for Admission: Talking incoherently suicide threats



3. Who reported behavior: Family

DIAGNOSIS: 1. Admission Note: Schizo—Aff. Schiz

2. New Case Conference Note: Acute Schiz. Episode

3. Discharge and date: Still in

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

2 Elopements

Presently AWOL

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(139)

K.O.

3so 2-21-73

NAME: Cutilli, Wm, 17 yo

AGE ON ADMISSION: 16 y. o. BIRTHDATE: 1-5-56

COMMITMENT: 1. Date on original and present: 1-3-72

2. Type on original and present: 403

3. Changes type and when:

ADMISSION 1. Admitting Physician: Dr. Buck

2. Reasons for Admission: Pt had been under treatment at Allentown State Hospital since Age 5. Pt can't speak.

3. Who reported behavior: Mother

DIAGNOSIS: 1. Admission Note: Schiz., childhood type

2. New Case Conference Note: Childhood Schitz

3. Discharge and date:

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

3 so. Dr. Lawrence
Mute
In school program on 3S0
Behavior problem—irratic behavior

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(140)
K.O.
Date: 2-22-73

NAME: Elizabeth Edwards
AGE ON ADMISSION: BIRTHDATE: Present Age:

COMMITMENT: 1. Date on original and present: 11-16-72
2. Type on original and present: 403
3. Changes type and when:

ADMISSION: 1. Admitting Physician: Dr. Armstrong
2. Reasons for Admission: Suicidal gestures
3. Who reported behavior: Pt & social worker

DIAGNOSIS: 1. Admission Note: Adolescent Adjust. Rx
2. New Case Conference Note:
3. Discharge and date
4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Liz is a pt of Dr. Armstrong in the Open Unit Bld. 9. She in involved in the school program, & group therapy 2 x a week.



(141)
2/7/73
KO

NAME: Deborah Geiger, 16.7
AGE ON ADMISSION: 16 BIRTHDATE: 7-13-56

COMMITMENT: 1. Date on original and present: 1-17-73
2. Type on original and present: 403
3. Changes type and when: None

ADMISSION: 1. Admitting Physician: Dr. Kratza
2. Reasons for Admission: Chaos in life; multiple destructive tendencies
3. Who reported behavior: Parents

DIAGNOSIS: 1. Admission Note: Reactive disorder
2. New Case Conference Note: None
3. Discharge and date
4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Involved in the school program, group therapy 2 x a week. Dr. Kratza is her doctor.
Family Fx.
Mostly cooperative.
No meds

---

(142)

NAME: Gallagher, Mary Lou
AGE ON ADMISSION: 15 BIRTHDATE: 9/15/57

COMMITMENT: 1. Date on original and present: Original 8/28/72 Present 10/26/72

2. Type on original and present: Original 403 Present 403

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Dr. Wicoff

2. Reason for Admission: Rebellion, aggressive behavior. Runaway, threatening to take drugs. Refusing out-patient care.

3. Who reported behavior: Father, Mr. Joseph Gallagher Mother, Mrs. Gallagher

DIAGNOSIS: 1. Admission Note: unsocialized agressive reaction of adolescence.

2. New Case Conference Note:

3. Discharge and date 2/12/73 AMA

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Marylou was a pt of Dr. Armstrong in the Open Unit. While there, she had at least 2 serious episodes of drug taking, and 2 elopements, which necessitated her transfer to the closed unit.

She was admitted into the drug program at HSH on 2/6/73 on 2/12/73 she was discharged AMA.

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(143)

Date: 2-22-73

NAME: Steve Gentile

AGE ON ADMISSION: 17 BIRTHDATE: 3-20-54 Present Age: 18.11



COMMITMENT: 1. Date on original and present: 8-24-71

2. Type on original and present: 403

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Dr. Ivins

2. Reasons for Admission: Pt is extremely violent, striking family, biting father.

3. Who reported behavior: Father

DIAGNOSIS: 1. Admission Note: Schizophrenia, acute undifferentiated

2. New Case Conference Note: Schiz., Chronic undifferentiated

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Pt is under care of Dr. Hammer. At present he is in the closed unit. He has been in the Open unit at times, but became increasingly bizare & became assaulting to his father the last time he was in the Open unit.

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(144)

2/7/73

K.O.

NAME: Tom Hockenberry, 15.8

AGE ON ADMISSION: 15 BIRTHDATE: 5-28-57

COMMITMENT: 1. Date on original and present: Sept 20, 1972

2. Type on original and present: 403 (original & present)

3. Changes type and when: None

ADMISSION: 1. Admitting Physician: Dr. Bluitt

2. Reasons for Admission: Tom had been on Qualude, Marijuana, LSD, History in Montgomery County Home of overtly psychotic behavior and a bizare suicide attempt. He had threatened and assaulted his father.

3. Who reported behavior: Pt and Father

DIAGNOSIS: 1. Admission Note: Drug dependence

2. New Case Conference Note: Adolescent & Drug Rx accompanied by mixed drug abuse

3. Discharge and date

4. Present: Same

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Tom was admitted to 4so. He was assigned to Dr. Hammer, of the adolescent service. He was transferred to Bld. 9 Sept. 29, 1972. Oct 9 he was transferred back to Bld. 4 for acting out behavior.

Oct 25 he was transferred to Bld. 9.

11/1—Tom eloped—on return was placed on 4so.

2/5—Trans to Bld 9

Attends school program, music therapy, 2 group therapies/wk. Takes Meds

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(145)

Date: 2/15/73

NAME: Hutchins, Judy

AGE ON ADMISSION: 17 BIRTHDATE: 9/20/55 Present Age: 17

COMMITMENT: 1. Date on original and present 11/27/72

2. Type on original and present: 403



3. Changes type and when:

ADMISSION: 1. Admitting Physician: Wendell

2. Reasons for Admission: bizarre behavior

3. Who reported behavior: Parents, BSU

DIAGNOSIS: 1. Admission Note: R/o Acute Schizophrenic reaction

2. New Case Conference Note: Acute schizophrenic reaction 295.4

3. Discharge and date: 295.4 2/8/73

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Admitted to Bldg 4. Rx'd with Phenothiazines: Accepted to Adolescent Service to Dr. Lustig Transferred to Bldg 9. Rx'd with milieu, family & pharmaco-therapy.

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(146)

Feb. 7, 1973

NAME: Golden, Sally

AGE ON ADMISSION: 14.8 BIRTHDATE: 4-13-58 Present Age: 14.10

COMMITMENT: 1. Date on original and present: 12-15-72

2. Type on original and present: 403

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Coin C. Lindquist, M.D.

2. Reasons for Admission: Suicide attempt, ideation.

3. Who reported behavior: Pt.

DIAGNOSIS: 1. Admission Note: 1 Psychoneurotic depression of suicidal ideation 2. Adol. Adj Rx with hysterical feature

2. New Case Conference Note:
3. Discharge and date
4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Admitted to #4 12.15
Transferred to # 9 12.18
Dr. Armstrong
Attended School, O.T., A.T., Gp.T., Rt. until started school full day.
Family Tx
Takes meds
No problem

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(147)
2/7/73
K.O.

NAME: Micheal King, 14.7

AGE ON ADMISSION: 14 BIRTHDATE: 7-3-58

COMMITMENT: 1. Date on original and present: 11/2/72
2. Type on original and present: 403
3. Changes type and when: None

ADMISSION: 1. Admitting Physician: Dr. Armstrong
2. Reasons for Admission: Mike stayed in his room at home for 43 days, refused O.P. help; has severe school phobia & refused to attend school
3. Who reported behavior: Mother

DIAGNOSIS: 1. Admission Note: Schizoid Personality, Severe 301.2



2. New Case Conference Note: Schizoid personality with school phobia
3. Discharge and date
4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Mike was admitted directly to the adolescent unit. He is involved in school here, and 2 group Tx a week. He is a pt of Dr. Rosen. He is cooperative on the unit, but the staff feels that his will be a long stay.

Cooperative.
Takes meds

---

(148)
K.O.
3so 2-21-73

NAME: Lucas, Walter 19.3 y.o.

AGE ON ADMISSION: 17. BIRTHDATE: 10-30-53

COMMITMENT: 1. Date on original and present: 7-31-70 8-29-72
2. Type on original and present: 416 402
3. Changes type and when:

ADMISSION: 1. Admitting Physician: Dr. Newman
2. Reasons for Admission: Transfer for ESSH retardation, "schiz, process" Chronic brain syndrome
3. Who reported behavior: Paul Goldberg of ESSH

DIAGNOSIS: 1. Admission Note: Mental retardation with Psychosis R/o Schiz, latent type

2. New Case Conference Note: Moderate mental retardation

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

24 times in seclusion from Aug. 13, 1970 to 6-8-72

Pt on 3S—Dr. Lawrence

In the School Program on 3So

He is a behavior problem—Impulsive

---

(149)

D.B.

Date: 2/21/73

NAME: McCauley, Mary Ellen

AGE ON ADMISSION: 16 BIRTHDATE: 2/26/56 Present Age: 16.11

COMMITMENT: 1. Date on original and present 11/7/72

2. Type on original and present: 403-403

3. Changes type and when:

Admission: 1. Admitting Physician: Dr. Wicoff

2. Reasons for Admission: Seceral & Alcohol Overdose—Temper Tantrums and rebellious behavior at home reaction of adolescence.

3. Who reported behavior: Dr. Fitti, BSU III; Parents

DIAGNOSIS: 1. Admission Note: Adjustment reaction of adolesence.

2. New Case Conference Note:

3. Discharge and date

4. Present:



PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Mary Ellen is a pt of Dr. Armstrong. She is enrolled in the school program, has group Tx 2 times a week. She has individual therapy with Mrs. Thompson.

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(150)

NAME: Mosco, Benjiman

AGE ON ADMISSION: 14yrs. BIRTHDATE: 12-20-57 (15.2 yrs.)

COMMITMENT: 1. Date on original and present: 5-15-72

2. Type on original and present: 403

3. Changes type and when: None

ADMISSION: 1. Admitting Physician: Mary P. Siegel, M.D.

2. Reasons for Admission: Behavior problem: Sexual acting out, foul language, physically abusing step-mother, running away, crashing family car, drugs.

3. Who reported behavior: Step-mother, Gandenzia Hacek

DIAGNOSIS: 1. Admission Note: 308.4, Unsocialized aggressive reaction of adolescence.

2. New Case Conference Note. Same

3. Discharge and date: 11/22/72—STL; Renewed 12/22/72

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Pt. admitted to closed unit on 5/15/72 and was transferred to the open unit on the Adolescent Service on

5/23/72 under the care of Dr. Hanno. Received individual & group therapy and was enrolled in the special education school program.

Family was seen in 10/72, 11/72, & 12/72 in family therapy with Family Service. (Media). Presently pt. is an STL—to be discharged as soon as father comes to hospital to sign papers.

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(151)
2/7/73
E L

NAME: Moss, Alan

AGE ON ADMISSION: 15 yrs BIRTHDATE: 3-24-57 (15.11 yrs)

COMMITMENT: 1. Date on original and present: 1-10-73

2. Type on original and present: 403

3. Changes type and when: None

ADMISSION: 1. Admitting Physician: G. P. Kratsa, MD.

2. Reasons for Admission: Depressed and suicidal

3. Who reported behavior: Patient

DIAGNOSIS: 1. Admission Note: Depressive Reaction

2. New Case Conference Note:

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Patient admitted to Closed Unit (5s) on 1-10-73 and was transferred to Bldg 9 on 1-13-73, Adolescent Service under care of Dr. Kratsa. Attended program on Unit, OT,



Art Therapy, Recreation Therapy & Group Th. Was entered into School Program Bldg 2 on 1/24/73. Family was seen 1/13/73; 1/19/73; 2/2/73 in Family Therapy. Further Neurological Studies are indicated and have been scheduled.

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(152)
K.O.
(IN) 2-21-73

NAME: Osbourne, Sue 16.4

AGE ON ADMISSION: 16 BIRTHDATE: 10-7-56

COMMITMENT: 1. Date on original and present: 1-22-73

2. Type on original and present: 403

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Dr. Wic-off

2. Reasons for Admission: Taking I.V. methadrine for 2 yrs

3. Who reported behavior: Pt.

DIAGNOSIS: 1. Admission Note: Habituation —Methadrine with recent hallucinations auditory & visual

2. New Case Conference Note: Adjustment Rx of Adolesc. with drug abuse.

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Pt admitted to drug program—1 No.—Dr. Zal.

Involved in group therapies.

(153)
K.O.
(35) 2-21-73

NAME: Parmed, David—16.8

AGE ON ADMISSION: 16 BIRTHDATE: 6-1-56

COMMITMENT: 1. Date on original and present: 6-5-72

2. Type on original and present: 403

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Dr. Siegel

2. Reasons for Admission: Transfer from ESSH —Childhood Schiz.

3. Who reported behavior: ESSH—Bill Scott

DIAGNOSIS: 1. Admission Note: Childhood Schiz.

2. New Case Conference Note: Same

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

3 So—Dr. Lawrence

In school program on 3 So

Behavior problem—Aggressive, impulsive

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(154)
2/7/73

NAME: Pollock, Michael (Nick)

AGE ON ADMISSION: 16 BIRTHDATE: 12-18-55 Present Age

COMMITMENT: 1. Date on original and present: 11-2-72



2. Type on original and present: 406

3. Changes type and when:

ADMISSION: 1. Admitting Physician: David N. Wicoff, M.D.

2. Reasons for Admission: Patient describes dissociative state while stealing a car and breaking into another. Several past suicidal attempts. Has heard voices & has had visual hallucinations. Judgment inmature impulsive. Suspiciousness

3. Who reported behavior: Patient.

DIAGNOSIS: 1. Admission Note: Border line Psychosis w/depression

Drug Habituation—LSD

2. New Case Conference Note: Schizoid personality, severe

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status.)

Institutionalized since 5 years old.

11-8-72 refused A.M. MEDS "doesn't want it"

11.14 needed additional meds for agitation.

11.16 off grounds returned by guards & nurses.

11-25 refused AM MEDS

12.6 agitated & fearful, banging hand on wall, threatening, talking of hurting himself and dying.

Transfer to Bldg 4

12.8 refused same meds

12.28 pt. reported pains in hand & wrist from agitation & hitting a window

12.28 refused meds

1.1.73 broke glass in candy machine in lobby

1.2 refused all meds

1.3 extreme agitation—put fist & arm through window—cut's

1.5 reported severe headache and difficulty breathing from "anxiety"

1.7 reported extreme depression over weekend & drug usage

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(155)

1.10 scratched arm with razor in suicidal gesture upon postponement of an appt.

1.22 stated he was "losing control"—requested meds.

1.29 reports LSD usage over weekend—upset by flashbacks—

Transfer to Bldg 4

1.30 refused AM meds

11 31 Return to Bldg 9

2.4 Pt. eloped

2.6 returned by Mrs. Iverson—laceration of left wrist, self-inflicted

To Bldg 4

2-12 Return to Bldg 9—

—Pt. asks consistantly for help but responds minimally to attempts by the staff.—

MED Feb

Prolixin 5 mgm QID

Donnatal tab + TID

Multivits + OD

Artane + mgm QID

Peotafrave 50 mgm TID [triangle] QID

Benadryl (elix) 100 mgm H.S.



Thorazine 10 mgm PRN (for Flashbacks or Hallucinations)

Mellaril 75 mgm PRN (agitation)

Calfeoget tab (headache)

Tigan 250 mgm PRN

D/C Thorazine 50 mgm Im

PROGRAM

School in bldg.—daily

Art Therapy—daily

Recreation. Therapy—daily

Group Therapy—2x weekly

Indiv. Therapy—2x weekly

Counseling (Brassell)—On Demand

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(156)

NAME: Saunders, Peggy Ann

AGE ON ADMISSION: 17 3/15/55 BIRTHDATE: 3/10/55

COMMITMENT: 1. Date on original and present: 2/2/73

2. Type on original and present: 403

3. Changes type and when:

ADMISSION: Admitting Physician: Wicoff

2. Reasons for Admission: Retarded, Brain damaged management [Illegible]

3. Who reported behavior: School

DIAGNOSIS: 1. Admission Note: Mental Retard Explosive BEHAV

2. New Case Conference Note: C 5

3. Discharge and date C 5

Present: Same

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Closed Ward.

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(157)

Date: 2/15/73

NAME: Taylor, Thomas

AGE ON ADMISSION: BIRTHDATE: 5/27/58 Present Age: 14

COMMITMENT: 1. Date on original and present: 2/2/73

2. Type on original and present: 403

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Gold

2. Reasons for Admission: Suicidal ideation

3. Who reported behavior: Children's Cottage

DIAGNOSIS: 1. Admission Note: Adjustment reaction of adolescence with suicidal ideation.

2. New Case Conference Note: Schizophrenia, latent type 295.5

3. Discharge and date

4. Present: 295.5

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Admitted to Bldg. 4. Assigned to Dr. Lusig. Rx'd with phenothiazine, resulting in rapid reconstitution. Transferred to Bldg 9. Eloped. Transferred back to Bldg 4.



(158)

2/7/73

NAME: Terence Thomson Present Age: 18.9

AGE ON ADMISSION: 17.4 BIRTHDATE: 3-3-54

COMMITMENT: 1. Date on original and present: 8/20/71 2/7/73

2. Type on original and present: 403 40?

3. Changes type and when: None

ADMISSION: 1. Admitting Physician: B. H. Armstrong, MD.

2. Reasons for Admission: Destructive to house breaking furniture; impaired judgment, pre occupation with exhibitionistic sex, threatening sexual & physical to mother.

3. Who reported behavior: Parents.

DIAGNOSIS: 1. Admission Note: Undiff. Schiz. Reaction 295.99 ~~Mental Retardation 310~~

2. New Case Conference Note: Passive—aggressive personality. Mental retardation, Mild. Ampathy [Illegible]

3. Discharge and date

4. Present: Same

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Admitted by Dr. Armstrong. On Adolescent Program, School Program, group therapy, family counseling. Cooperative, friendly, gets along with peers, and staff. Very inactive, even babyish when with his parents. Pt. has done well in school, adjusted well to Adolesc. program. Goals include getting into some sort of job training (eg. Bakery), later get job, live at home. Needs to be

communicative, responsible, grown-up in relationship with his parents.

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(159)
K.O.
2-21-73

NAME: Vantine, Michael 16. OY.O.

AGE ON ADMISSION: 15 y.o. BIRTHDATE: 2-7-57

COMMITMENT: 1. Date on original and present: 8-24-72

2. Type on original and present: 403

3. Changes type and when: None

ADMISSION: 1. Admitting Physician: Dr. Armstrong

2. Reasons for Admission: Transfer from Friends Hospital due to lack of funds; history of barbiturate dependency, seizures. Suicidal attempt 6 wks prior to admission.

3. Who reported behavior: Child case worker

DIAGNOSIS: 1. Admission Note: Schiz, latent type; adjustment Rx of adolesence with depression; minimal cerebellar dysfunction

2. New Case Conference Note:

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

9-18-72—cut arm, not seriously

11-8-72—suspected of selling drugs at school

11-13-72—attempted to hang himself

12-11-72—stole medications fr 9So medication cabinet



12-11-72—possible drug overdose

12-26-72—drinking, & found with pills in his possession

Dr. Hammer's pt. when not in Bld 9 he is a pt of 4so

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(160)
February 21, 1973

NAME Graber, James

AGE ON ADMISSION: 17 BIRTHDATE: 4/26/55

Present Age: 17 yrs.

COMMITMENT: 1. Date on original and present: 2/2/73

2. Type on original and present: 405-403

3. Changes type and when: Changed to 403 on 2/7/73

ADMISSION: 1. Admitting Physician: Dr. Wicoff

2. Reasons for Admission: Valium Overdose, suicidal ideations, assaultive behavior in the home.

3. Who reported behavior: Mrs. Virginia Owen (Child case worker) Father Francis Serick (Principal of Msr. Bonner H. S.)

DIAGNOSIS: 1. Admission Note: Depressive Reaction.

2. New Case Conference Note:

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Pt. evaluated & accepted by adolescent Service. Transferred to open building 2/2/73 under care of Dr. Gus Kratsa. Eloped 2/13/73. Current on U.A.

(161)
Date: 2/14/73

NAME: Anita Jenkins
AGE ON ADMISSION: 16 BIRTHDATE:
Present Age:
COMMITMENT: 1. Date on original and present: 405—11/29/72
2. Type on original and present: 405—408 12/5/72
3. Changes type and when: 405—408
ADMISSION: 1. Admitting Physician: Dr. Wicoff
2. Reasons for Admission: charges of assault & battery while at Sleighten Farm.
3. Who reported behavior: Sleighten Farm
DIAGNOSIS: 1. Admission Note: 1. Mild Mental Retardation 2. Antisocial personality
2. New Case Conference Note: Unsocialized aggresgressive vxn of adolescence
3. Dicharge and date
4. Present: Unsocialized aggressive vxn of adolescence
PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)
Admitted to 5N—Dr. Wojcrechosk
Acute Treatment Unit—I.C.U.
Program: individual therapy, school tutoring, group therapy (5N), remotivation group, occupational therapy
Current status—controllable aggressive tendencies,, but tends to be provocative with vulnerable, Individual She attends school and group, but is easily discouraged and feels worthless. She goes weekly for weekend visits at home.



(162)
K.O.
2-22-73

NAME: Rhinehart, David 16.4 y.o
AGE ON ADMISSION: 16yo BIRTHDATE: 10-3-56
COMMITMENT: 1. Date on original and present: 1-11-73
2. Type on original and present: 408
3. Changes type and when:
ADMISSION: 1. Admitting Physician: Dr. Wicoff
2. Reasons for Admission: Court—Stealing cars
3. Who reported behavior: Parents
DIAGNOSIS: 1. Admission Note: Deferred
2. New Case Conference Note: Non psychotic organic brain syndrome antisocial personality
3. Discharge and date
4. Present:
PROGRSS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)
David had been in the adolescent service under Dr. Kratsa's care in the Closed Unit. He was transferred to the open unit. While there he stole a car. He was transferred to the Closed Unit again. ~~He has since had a Court hearing at which time~~

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(163)
K.O.
2-22-73

4N
NAME: Schriber, Elizabeth 14.3

AGE ON ADMISSION: 14 BIRTHDATE: 11-25-58

COMMITMENT: 1. Date on original and present: 1-25-73

2. Type on original and present: 408

3. Changes type and when: extended indefinitely 2-4-73

ADMISSION: 1. Admitting Physician: Dr. Wic-off

2. Reasons for Admission: 10 day evaluation at request of court

3. Who reported behavior:

DIAGNOSIS: 1. Admission Note: Adjustment Rx of Adolescence; suicide attempt and ideation

2. New Case Conference Note:

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Pt is on 4No, Adolescence service. Dr. Kratsa is her doctor. She is enrolled in VAS.

She will be transferred from the Closed unit to the Open unit shortly.

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(164)
K.O.
2-23-73

(4S)

NAME: Willett, Steve, 16.9 yo

AGE ON ADMISSION: 16 BIRTHDATE: 4-26-56



COMMITMENT: 1. Date on original and present: 1-23-73

2. Type on original and present: 408

3. Changes type and when: Extention on 2-2-73 for 30 days per Judge Reed

ADMISSION: 1. Admitting Physician: Dr. Wic-off

2. Reasons for Admission: Violation of probation

3. Who reported behavior: Judge Reed (?)

DIAGNOSIS: 1. Admission Note: Runaway rx of adolescence (?)

2. New Case Conference Note: Adolescent adjust-ment rx

R/o Drug dependence

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Steve is a pt of Dr. Kratsa on 4So.

Adolescent service, locked building.

Court hearing 2-21-73—recommendation to be sent to St. Gabriel.

(165)
EXHIBIT C

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HAVERFORD STATE
LEVINE, Leslie
**9645 1**

SUMMARY

This is the first Haverford State Hospital admission for this 15 year old, white, single, 10th grade student admitted here 10-11-72 on a 403 commitment signed by her mother. The patient's mother and her two sisters were seen along with the patient by Dr. Arenowitz at Base Service Unit III for 9 sessions during the months prior to admission because of family quarrels. On the day of admission the patient felt as she stated "closed in" by the mother and she threatened the mother with a kitchen knife. The mother contacted Dr. Arenowitz who recommended hospitalization at Haverford State Hospital.

The patient's parents have been separated since the patient was approximately 5 years of age. Patient did not see her father again until March, 1971. During the past 2 school years Leslie and her mother have had battles over everything Leslie has wanted to do. Subsequently, Leslie began having problems in school. In an effort to help her finish the school year she was sent to Florida from March to June, 1971, and February to June, 1972, to live with her father and step-mother and complete the school year. Leslie idolizes her father although the period spent with him and her step-mother were not idealic because of the step-mother making her do domestic duties.

On admission here the patient was admitted to a closed ward and evaluated by the Adolescent Service on



October 12, 1972. She was than transferred to the open adolescent building where she remained until discharge. She was placed on Stelazine 2 mgs. tid until November 13th when psychiatric medications were discontinued. While on the open ward she participated in group therapy twice a week, was assigned a counselor and seen individually by either Dr. Armstrong or Dr. Rosen as was needed. She also attended school regularly. She and the family were seen by Dr. Lustig on a regular basis in Family Psychotherapy.

New Case Conference held on October 16, 1972, revealed a diagnosis of Adolescent Adjustment Reaction. Psychological testing revealed a 15 year old girl functioning within the average range of intelligence with indications that her poor school achievement had been due to basic difficulty in handling specific facts. She revealed a tendency to overlook details. She seen as a highly infantile individual who responded hostily to the environment and who used all her resources to contain her negative feelings. It was felt that at times of stress, particularly when related to quarrels with her mother, acting out behavior was highly likely.

Electroencephalogram, neurological and routine lab studies were all normal. Routine physical examination was normal.

(166)

On the open ward patient remained rather withdrawn, socializing minimally with the patients and staff. If an incident occurred, she seemed always to be present but denied any active participation in the scene. Finally towards the second week in October she became involved with another patient in a number of incidents in which

she broke minor rules on the floor, became verbally abusive, began to tease another patient and she was transferred to the closed unit on October 18th. On the closed ward she soon settled down, attending school and was given limited ground privileges. She was transferred back to the open ward on October 23rd where she remained on no medication until her discharge. Both the patient and her mother wish the patient to live with her father in Florida and complete the school year as done in the past. Both agreed to our recommendation of individual therapy while living with the father in Florida. Because of the chaotic family situation in Florida discharge had to be delayed until its resolution. When this was done the patient was discharged on 11-16-72.

DIAGNOSIS: Adolescent adjustment reaction.

RECOMMENDATIONS: Patient to live with father in Florida and continue out-patient and individual therapy in Florida.

Howard Rosen, M.D.

HR/dmn/1s

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(167)

HAVERFORD STATE HOSPITAL
WEAND, Mark

SUMMARY:

PSYCHIATRIC HISTORY:

This 15 year old white boy was admitted to HSH on 6-24-72 under a 402 commitment following transfer from Osteopathic Hospital where he had remained overnight. His admission there was precipitated by ingestion of approximately 8 Valium and possible glue sniffing. While



under the influence of drugs the patient tried to kill his uncle with a knife. At the time of his admission to HSH he was still intoxicated from the use of drugs and was extremely hostile; at that time it was not possible to perform an adequate mental status examination. Subsequent mental status the following day revealed the patient to be oriented in all spheres and to exhibit no evidence of psychosis. However marked impulsivity and immature judgment were present.

Past psychiatric history included the patient having been placed on probation after a drug abuse charge and a court evaluation on February 20, 1972. Mark has a 1½ year history of underacheiving, truancy and drug abuse.

Psychological Evaluation was done by the court on February 20, 1972 and revealed a full scale I.Q. of 82 (the dull normal range of intelligence.) It was noted that he had impaired concept formation.

His parents were divorced in 1960. His mother lives with an unmarried brother and sister and the maternal grandmother. Mark has a 17 year old sister.

New Case Conference was held on July 3, 1972; diagnosis at that time was 309.14 Non-psychotic organic brain syndrome, Valium and others, and 306.4 Unsocialized aggressive reaction of adolescence.

During the month of July the patient was seen by Dr. Rashkis in group therapy twice per week. On 7-12-72 he was transferred to Adolescent Service Open Unit. He received no medication other than Benedryl 100 mgmh.s. Subsequent laboratory tests, EEG and Neurological Examination were all within normal limits. On the open unit the patient attended group therapy twice a week and was seen individually once a week by Dr. Armstrong.

After approximately 3 weeks it was decided in Staff Conference that the patient's family should be seen in family therapy. This was begun in early August on a once a week basis. The patient's aunt, uncle and mother were included in most sessions. In one session the sister came, (168) and in one other session the maternal grandmother came.

Due to complaining of being depressed the patient was placed on Tofranil 25 mgm t.i.d. for 3 days then Tofranil 50 mgm t.i.d.. Tofranil was discontinued on 8-21-72 with no effect at that time. Patient was placed on Elavil 25 mgm t.i.d. for 3 days and then Elavil 50 mgm t.i.d.. On 8-10-72 the patient was transferred to 5 South Adolescent Service Closed Unit due to his having taken 3 Tuinal and having sustained an unsteady gait, slurred speech and uncontrolled behavior while in the open building. He was transferred back to the Adolescent Service Open Building on 8-14-72. The patient continued to state that he felt he was being kept in the hospital against his will and he denied that there was any problem other than his drug usage. However it was apparent from his behavior toward the staff and other patients, that there is marked passive-aggressiveness and disproportionate hostility and suspicion in dealing with others. The patient was considered appropriate for the Adolescent Program because of his personality problems, the drug abuse was judged by the staff to be symptomatic of these problems. It was the best judgment of the Adolescent Service physician that a drug treatment program per se was not the treatment choice, but the more appropriate modality was that of a milieu group. On Labor Day weekend the patient was given a weekend pass and he was given sufficient Elavil for 3 dosages a day for 4 days. He took the entire dose at one time and arrived in a comatose state back at



this hospital; he was transferred to Bryn Mawr Hospital and remained in the Intensive Care Unit for 24 hours before being transferred to the closed unit in Adolescent Therapy. Patient continued to be very angry, sullen and unreachable.

Family Therapy was continued with varying numbers of the family present. Patient continued in the Special Education School Program. He also continued in group therapy twice per week. Following the overdose of medication patient was placed on no medication with the exception of the small amount of Thorazine for agitation 25 mgm which was continued for 7 days and than discontinued. In October, family therapy consisted of the patient and his mother only, this was an attempt to allow them to break away from the mother's primary family and to live in an apartment. The patient was placed on Short Term Leave on 10-18-72. He was to become involved in out-patient therapy prior to discharge. On 10-24-72 the patient was brought back to the Adolescent Service by the police after being questioned due to false accusation of stealing. He also appeared to be on drugs and was requested to give a urine sample which he refused. He (169) then superficially slashed his wrist and was readmitted to the closed building. He was transferred back to the Adolescent Service Open Unit on 10-26-72. He was again placed on Short Term Leave on 11-1-72 with the understanding that he become actively involved in out-patient psychotherapy at B.S.U. II and to continue in HSH Special Education Program. He was on no psychiatric medication. In all, patient was seen in group therapy 28 times, family therapy 8 times and individual therapy 7 times.

BHA/dmn

Barbara H. Armstrong, M.D.

(170)

HAVERFORD STATE
GENTILE, Stephen
7100

SUMMARY

This 18 year old, white male has been a patient since August 24, 1971, when he was admitted under Section 403 (signed by parents) for his having become violent and aggressive towards his family and younger children in his neighborhood. A previous hospitalization from 12-29-70 to 4-21-71 terminated when patient was discharged against medical advice from unauthorized absence. His diagnosis at that time was—Schizophrenic Reaction, chronic undifferentiated type. At the time of admission and subsequently the patient presented with confusion, disorientation, inappropriate affect, often giggling without apparent cause, ideas of reference, unprovoked aggressive acts toward Staff and considerable degree of hostility in the form of restlessness and agitation.

Chemotherapy and a course of ECT from September-October 1971, had only marginal involvement for the patient. This examiner assumed management of Stephen's case starting in January of 1972. More reality contact and less confusion was noted in March and medication was readjusted. Patient was extremely resistant to being transferred to the open unit of the Adolescent Service. He frequently refused structure and support. The Adolescent Staff was able to maintain him in the open unit from May through continual support but only with some difficulty. Patient became confused, was involved in antisocial acting-out and fecal smearing, and was transferred to a closed unit from August 4 to October 9, 1972. He returned to the open unit after he became better able to



handle a less structured environment and after he stabilized on phenothiazines.

Since his return to the open unit, patient has been in a modified school program, receiving chemotherapy and family therapy on a weekly basis. His weekends home from Haverford State Hospital have been uneventful, although parents report patient has difficulty in socialization, stays close to the family and is uneasy when in public.

Plans are for gradual increase in patient's school program and reduction of medication to an out-patient maintenance level before discharge. The patient has required high doses of medication in order to be able to function and his improvement has been marginal until now. He is still considered incompetent, appearing confused as to his goals, lacking any insight and judgment as to his reasons for hospitalization.

Diagnosis:— Schizophrenia, chronic undifferentiated type.

Currently, the patient is placed on the following medications:— Artane 1 mg. bid, Benadryl 100 mgs. hs and Thorazine 300 mgs. qid. He has been scheduled for group therapy twice per week and individual therapy once per week. Patient has attended group therapy 33 times, Individual Therapy 16 times and Family Therapy 12 times.
CH/ frg

11/28/72

Carl Hammer, M.D.

(171)

HAVERFORD STATE
MATHEWS, Vicki
9416

SUMMARY

*Psychiatric History*

This is the first Haverford State Hospital admission for this 15 year old, white, 9th grade student, admitted to this hospital 8-9-72 on a 403 commitment, signed by her parents. She was brought to the hospital by the police for psychiatric evaluation with the approval of the Assistant Superintendent Dr. Phillips, after being picked up in the park in an incoherent, assaultive state along with several young men. Patient had run away from home approximately 10 days prior to admission.

The patient and her family had been seen for family psychotherapy in the Irving Schwartz Institute in 1971 and the Philadelphia Child Guidance Clinic in 1972. Family terminated both these contacts on their own because they sought individual psychotherapy for her with Dr. Curran. After several sessions the latter left for vacation. The family stated that Dr. Curran's advice was to let Vicki live away from home and check in with them periodically. She subsequently ran away and they had no contact with her other than occasionally by telephone until summoned by the police on August 9th, as noted above.

The patient has failed and repeated the 7th grade. The family states that she has a reputation as the "school tramp" and that her siblings are embarrassed by her behavior. She has been picked up by the police on several occasions although no charges were pressed. On one occasion last year she ran away to Elkton, Maryland and stayed away overnight on several other occasions. At age 3 years, Vicki was evaluated at the University of Pennsylvania for stammering. In the second grade the parents and the child were seen by Dr. Herman Staples when Vicki refused to go to school.



On initial status patient appeared as a small adolescent, oriented fully and unsteady of gait. There was much evidence of anger and hostility. She admitted trying to commit suicide while in jail (multiple scratches on both wrists and arms)—"What do I have to live for—a bunch of shit!" She admits to having abused drugs for 6 to 7 months (Quaalude and Tuinal) and said that she had 2 Tuinals that morning. Prior to this she smoked hashish and marijuana. She vented much hostility towards her family, particularly her father, "My family is screwed up. What can I do? I tried running away and it just got me in jail." In addition, the patient told her father that she had been raped the night before.

(172)

Psychological testing was done and compared to the report from the Irving Schwartz Institute (which the family was very reluctant to release to us). Based on this report, there was no evidence of a thought disorder. The patient was currently functioning on a lower average range of intelligence, giving evidence of bright, normal and even superior learning capacities, only partially utilized at the time of testing. (Negative attitudes toward school and clear deficit in school related tasks suggest this area as the focal point of much of her current difficulties.) In general, she was seen as a frightened girl, who was attempting to strike out at her surroundings in self defense.

Social Service workers' impression was that the parents have been seeking professional help since she was 3 years old. The family has been extremely critical of past professional psychiatric help and they see Vicki's problem as an individual one and not as one of the family or between the marital partners. They are very eager for placement outside of the home.

*Hospital Course*

*Progress in the hospital.*

The patient was admitted to a closed facility. For the first 48 hours she required psychotropic medication and confinement in order to help her to control herself. She remained unsteady of gait and verbally abusive. Within a few days, however, she settled down and received ground privileges.

On August 9, 1972 she claimed to have been struck by another patient while making a telephone call. She eloped from the hospital that weekend. On August 23, 1972 she was transferred to the open adolescent facility and on August 25, 1972 the family was seen to preliminarily sound them out on future planning. Mrs. Mathews, in particular, did not desire Vicki to return home. The preliminary recommendations of the Adolescent Service were conveyed to the family in that the patient needed a structured, residential school setting and should not return to the family.

Meanwhile, the patient continued on no medication; she attended group therapy on a twice a week basis; she was assigned to an individual counsellor, and was seen individually by either Dr. Rosen or Dr. Armstrong, as required.



(173)

On September 5th, the patient became increasingly agitated. She refused to go to school, which was starting that week and was quite obviously concerned about disposition. The agitation increased with a number of incidents on the ward, including threatening to elope and smoke pot so that ultimately the patient was transferred back to a closed ward on September 12, 1972. She remained there for approximately 3 days and soon calmed down and she was able to attend school from the closed building on grounds privileges, and then was returned to the open unit on September 15.

At Staff Conference in mid-September two recommendations were made—one for residential schooling, since it seemed desirable to remove the patient from the family setting because the family had been so rejecting of her and scapegoating her. In view of the patient's apparent willingness for residential placement, and necessary financial resources, a school such as Devereaux, which is a residential treatment center, was recommended to them. Secondly, if the patient's financial resources would not permit private residential placement, it was recommended that the family take the patient to court to be declared incorrigible. Three, the patient was not considered suitable for public school education because of the long history of emotional disturbance.

The patient was informed of the Adolescent Service's recommendations and the family was again consulted. Interviews were arranged at Devereaux for the family and the patient. The patient also made application to the George Junior Republic School in New York State.

On the ward the patient was started on Haldol 1 mg. tid. and Cogentin 1 mg. tid. The patient continued to

attend group and school uneventfully until the second week in October. At that time she became anxious and refused to attend certain assigned activities and became verbally abusive, breaking minor restrictions on the ward, especially harassing other patients. An attempt was made to deal with this on the open ward administratively but this failed and the patient had to be transferred to the closed ward again on 10-18-72. She remained there only a couple of days and saw that she was inappropriate in how she had acted. She was transferred back to the open ward 10-20-72 where she remained until her discharge on 11-7-72.

On admission, physical exam was unremarkable. Neurological exam was normal. EEG and routine admission studies were normal. GYN consult dated August 14, revealed no signs of forced sexual intercourse (see history —patient denied having intercourse as stated to father). Marital introitus.

(174)

Patient sustained a lower urinary tract infection and was treated with penicillin.

Her medication at time of discharge was Cogentin 1 mg. tid. and Haldol 1 mg. tid.

*Diagnosis:* Passive aggressive personality, aggressive type 301.81

*Disposition:* Discharge 11-7-72 to the parents for transfer to the Devereaux School.

HBR/em

Howard B. Rosen, M.D.



(175)

HAVERFORD STATE
BARTLEY, Kevin
8369 1

SUMMARY

This 16 year old male has been a patient since November, 1971 when he was admitted on a 403 commitment signed by his mother, as a transfer from Eastern State School and Hospital. He had been at Eastern State School and Hospital since January 11, 1968 with a diagnosis of organic brain syndrome with Epilepsy and Explosive Personality Disorder. He was transferred to the open unit of the adolescent service and came under this examiners supervision in January, 1972. He has continued to be hyper-sensitive to rejection from family and staff and often acts aggressively when depressed. Since the loss of his father, this patient has had many self doubts and low self esteem and has known to be accident prone and self destructive. With support and working with a therapeutic milieu of staff the patient has made considerable progress in recent months. He continues to require anti-convulsive medication and his seizures have been under control during his hospital stay. This patient has been known to interact with the staff and other patients in an aggressive way often asking to be hurt and punished. When self destructiveness or aggressiveness toward the staff became uncontrollable, the patient has required transfer to a closed unit for self protection or for protection of others. He generally responded well to these temporary restrictions and has not required extended use of the closed unit. At the present time the patient is living with his mother and siblings.

Since April, 1972, many referrals have been made toward finding a suitable school-vocational program in the community. Because of his being multi-handicapped with an organic seizure disorder and his emotional lability in the past, he had not been accepted. Efforts to work with his mother to allow her to become more receptive to his return to his home and community have been difficult, but have also improved considerably in recent months.

The patient was evaluated 11-20-72 by Elwyn for consideration for their school work program and it appears he may start there in the near future. Since 11-22-72, he has been on short term leave. Delays in finding transportation to our Special Education Program at Haverford State Hospital finally are being worked out.

Diagnostically, he remains 1) Organic Brain Syndrome with Epilepsy and 2) Personality Trait Disturbance, explosive type with depressive features. Tests have indicated his ability to work in a school vocational program and it is anticipated he will be discharged to Base Service Unit for follow-up care and controlled by chemotherapy once he has begun this program.

(176) Patient was placed on the following medications: Phenobarbital gr. 1 tid, Dilantin 100 mgs. tid and Valium 5 mgs. qid and Benadryl 150 mgs. hs plus 1 green placebo.

Patient has been scheduled for group therapy twice per week during his hospital stay. In all patient was in group therapy 42 times. Since January, 1972, he has been seen individually by Dr. Hammer in an approximate once per week basis. Actual attended sessions number 16 times.

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1s Carl Hammer, M.D.



Philadelphia, Pennsylvania

May 10, 1973

HEARING

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Before:

Honorable John Gibbons, J., Circuit Court Judge.

Honorable Thomas A. Masterson, J., District Court Judge.

Honorable Raymond J. Broderick, J., District Court Judge.

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Appearances:

David Ferleger, Esq., Stanley Abramson, Esq., Ronald Soskin, Esq., 121 South 18th Street, Philadelphia, Pennsylvania 19103, Attorneys for Plaintiffs.

Barry A. Roth, Esq., Assistant Attorney General, Department of Justice, Room 323, Health & Welfare Building, Harrisburg, Pennsylvania 17120, Attorney for Defendants.

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(3) JUDGE GIBBONS: May we have the appearances?

MR. FERLEGER: My name is David Ferleger, attorney for the plaintiffs Your Honor.

MR. ROTH: My name is Barry Roth, attorney for the defendants.

JUDGE MASTERSON: Are you a Deputy Attorney General?

MR. ROTH: Assistant Attorney General.

JUDGE MASTERSON: You are an Assistant Attorney General?

MR. ROTH: Yes, Your Honor.

MR. FERLEGER: Your Honor, this is Stanley Abramson, who is going to be a graduate from Rutgers Law School and this is Ronald Soskin, who will be a graduate from Pennsylvania Law School.

JUDGE MASTERSON: We have reviewed the papers in this case. Let me ask this general question: Does the promulgation of the regulations effective May 1st with respect to children 13 to 15 cure the problem as far as the plaintiffs are concerned as to that group of children?

MR. FERLEGER: No, Your Honor.

JUDGE MASTERSON: Why not?

(4) MR. FERLEGER: The reason being that the —on two grounds. From a due process point of view the regulations allow children to be brought into an institution and deprived of their liberties solely by reason of examinations of doctors. That is in a non-emergency situation.

JUDGE MASTERSON: That can be done in the Mental Health Act as to adults on the certification of two doctors. You or I, or anybody else can be dumped in for ten days or something like that.

MR. FERLEGER: In 1971 in the Dixon case, a three Judge court in the Western District ruled that section of the Mental Health Act unconstitutional. It can't be done any more.



JUDGE MASTERSON: What do they do now?

MR. FERLEGER: Right now the only way an adult can be brought into a hospital against his will, aside from the emergency situation, is by Court commitment.

JUDGE MASTERSON: What happens in the emergency situation?

MR. FERLEGER: In the emergency situation when somebody is dangerous to himself or to other people, in that situation the County Mental Health (5) Administrator can authorize commitment for the purposes of observation and protection.

JUDGE MASTERSON: It just can't be on the certification of the two doctors?

MR. FERLEGER: No.

JUDGE GIBBONS: But it can be on the certification of the County Mental Health Administrator?

MR. FERLEGER: In an emergency situation.

JUDGE GIBBONS: How does that add to the due process? Suppose the same thing were applicable to children?

MR. FERLEGER: If the situation was dangerousness, in that emergency situation I don't have any problem with children being brought in under that emergency section which is Section 205 of the Mental Health Act.

In the non-emergency situation it is improper now to deprive adults of their liberty without a hearing, and I think also it would be improper to deprive the children.

JUDGE GIBBONS: I am afraid that is a little bit simplistic. A child say of 6 years old who is taken to a pedi-

atric ward with an emergency (6) is deprived of his liberty, and yet if you ask the child did he want to go to the hospital, in 99 cases out of 100 he would object.

It seems to me we can't look at it quite as simplistically, the due process point. It is more involved.

MR. FERLEGER: Well, at first Your Honor I was responding to the Judge's question about children 13 and older under the regulations.

In response to your comment I think it is a little bit different when it is deprivation of liberty, which means institutionalization in an institution for mental health treatment. There are a number of cases which I have cited, one being Heryford v Parker which involved a 9 year old.

In that case the Court held that when this 9 year old feeble-minded child was to be committed to live at an institution for a period of time, not to have a broken arm fixed, but to live in an institution, that a Guardian Ad Litem had to be appointed.

JUDGE GIBBONS: It may be that a guardian procedure at some point would be appropriate and even necessary, but my difficulty with approaching (7) this solely from a due process standpoint is that a suicidal child is just as much in need of emergency medical attention as is a child with a broken arm. If you surround the treatment of potentially self-destructive mental illness with so many due process safeguards you may, particularly with respect to lower income people, build in a tendency not to resort to treatment. There seems to me to be a good deal more involved here than the due process problem.



MR. FERLEGER: I agree completely with what you said for the suicidal child who acts out in a way that is self-destructive. That situation, I think, clearly is the kind of thing that presently can be dealt with through the emergency procedure. There is no problem at all, I don't think, in any county in Pennsylvania with a parent bringing in a child who is going to kill himself. The problem is, for example at Haverford State Hospital, the majority of children are brought there not for the kind of behaviors which are delinquent, stealing and running away from home. For that kind of thing there is no emergency.

JUDGE GIBBONS: You may be able to (8) establish that. We can't accept that as the fact.

MR. FERLEGER: I understand that.

JUDGE GIBBONS: But no matter whether even if that is true the process of getting the child to the hospital, keeping in mind that presumptively until 18 the parent has a firm obligation to do so, can't be made so difficult that we would be defeating the purpose of the hospitals.

JUDGE MASTERSON: It seems to me that the problem is having a procedure for someone independent of the parent and the child to review the facts concerning the child's institutionalization. I don't think that that review should occur before the institutionalization, because I agree with Judge Gibbons that that may have a deterrent effect on people having their children institutionalized when they need to be. And it seems to me that due process, meaningful due process, is served if the procedure is available so that the unwilling child can have an independent person review the facts with respect to his institutionalization, and that's why my own preliminary is that the

May 1st regulations pretty much take the steam out of your case as to the 13 to 18 year olds.

(9) MR. FERLEGER: There have been very few cases, due process cases involving the mental health of minors. There have been a large number of cases which are cited throughout the papers submitted involving due process for adults. Those cases make it clear that for adults, adults can't be deprived of their liberty without all kinds of procedural protections. The Wisconsin three Judge court in Lessard v Schmidt just narrowed down commitment to adults to dangerousness in any case. Cases involving the commitment of juveniles have mainly been of the Gault type, cases which involve committing the juvenile to rehabilitate or treat the child to help cure behavior or in some cases to cure mental problems. When those cases have examined the situation they have said that the fact that parents or somebody else wants the kid in an institution, even for his own benefit, doesn't mean that due process doesn't have to be provided.

JUDGE MASTERSON: I think that there is a point at which the natural right of parents and the extremes of due process collide. I suppose technically you could argue, with just as much force, that I ought not to be able to spank a child, maybe I (10) shouldn't, until I go before a Magistrate and convict the child of errant behavior.

Now I think you can put these things under much too fine a microscope, and I am concerned about what I consider to be meaningful deprivations. I don't think it is terribly meaningful, it doesn't upset me much, that a parent can commit a child to a mental institution and the child may be there for three or four days against its will before an independent person reviews the circumstances



of their commitment. It really doesn't bother me that much that there may be that amount of deprivation because I think that the arguments for giving the parents the right to make the initial decision are, for me, very persuasive. I don't know how my brethren feel about that.

JUDGE GIBBONS: Another thing that disturbs me about this, about your case, it presumes that the hospital is in an adverse relationship to the child, or at least it presumes in the relief it requests that the hospital should be put in an adversary relationship with the child.

Now in the Gault situation that is clearly the case, although the original theory was otherwise, (11) it has quite clearly become the case that the child is being incarcerated for criminal behavior, and that the societal control is adversary. I don't think we can make the same assumption about the hospital.

You see we are dealing with infants, the parents have a parental responsibility. The State, at least during minority, also has a parent patriary responsibility, which it may be discharging through the hospital, and when you say a due process requirement you are assuming that the hospital can not accord due process; that it can not discharge the State's nonadversary responsibility.

After all, the hospital is, if anything, a potential adversary of the parent rather than the child.

MR. FERLEGER: Your Honor, the parents patriae concept is involved, and there is more than one case which says that in the case of admitting juveniles, parents patriae means that you have to provide due process which included in that case court type process.

In terms of the hospital being an adversary, I don't feel that the hospital is an adversary. (12) I feel that the hospital is sincere in its attempt to treat the children. However, the concept of physicians, of doctors, deciding whether deprivation of liberty is appropriate is the very thing that was rejected in the Dixon case as is the very thing that has been rejected—

JUDGE GIBBONS: That is a different situation.

JUDGE MASTERSON: In any event, I would agree that you can't give the doctors unreviewable authority, but it seems to me that it is cured once you establish a procedure where the doctor's decision is independently reviewed by someone who has responsibility to no one other than the child.

I think one of the things we would all like to know, what are the facts here?

JUDGE BRODERICK: May I ask a question along those lines?

JUDGE MASTERSON: Yes.

JUDGE BRODERICK: Mr. Ferleger, I have been concerned about your second statement here this morning, and that was in response to, I think, Judge Masterson's question to you as to whether or not these regulations that were recently enacted (13) didn't take care of the situation. And you said you were primarily, or words to that effect, concerned with what, I will use the term I don't think you did, the delinquent child. Not the child that needs emergency treatment for mental or an emotional disorder, but the delinquent child. And I have a problem trying to figure out how that delinquent child would get



into the State mental hospital such as Haverford. Can you answer that for me?

MR. FERLEGER: I will be glad to Your Honor.

JUDGE BRODERICK: How do they get in there?

MR. FERLEGER: First let me preface that by giving the factual basis which isn't before the Court, but it will take a sentence to mention it.

There is a study that is being done at Haverford by the Research Department, a computerized study of hundreds of adolescents admitted during a four year period, and they have computed the types of behaviors that bring kids into the hospital. I have just glanced at it briefly, and 20 or 30 per cent, I am not sure of the exact numbers, came in because of stealing.

(14) Now the reason is, to answer your question specifically, that kids do a lot of things that to juvenile court judges, and to the delinquency laws, look like delinquent type things, and to a psychiatrist are psychiatric symptoms of a mental problem. And for those kinds of things the parents very often have the alternative. They can go through the juvenile court process, or they can go through the hospital.

JUDGE BRODERICK: That's the one question I wanted to ask you.

JUDGE MASTERSON: Let me ask this.

JUDGE BRODERICK: Yes.

JUDGE MASTERSON: Do you want to deprive the parents of going the hospital route rather than the Juvenile Court?

MR. FERLEGER: No. I have no problem with the parents going the hospital route, but I think that just as in a juvenile court process the Judge makes the determination about whether or not the child is delinquent, so the mental health process Judge should decide whether or not the person is mentally ill.

JUDGE MASTERSON: So the Judges will have (15) to be reviewing all of these commitments of adolescents to State mental institutions?

MR. FERLEGER: Judges review all involuntary commitments of adults and I feel it would be proper to also review the commitments of juveniles.

JUDGE MASTERSON: I don't think they review all the involuntary commitments of adults unless a petition is filed.

MR. FERLEGER: But if there isn't a petition filed there can't be an involuntary commitment at all.

JUDGE BRODERICK: Do you know whether someone can get into the Haverford State Hospital as a delinquent without being sent there by the Court Mr. Roth?

MR. ROTH: Your Honor, I am not apprised of that. I would assume that the person would have to be sent there by the Court.

JUDGE BRODERICK: I have always been under that impression and I didn't know, and I am not saying that it is a good idea if a parent wants to avoid the juvenile legal machinery, but I had always been under the impression that a parent couldn't voluntarily go out and say, "Look, I have a bad boy (16) here and I want you to take him in." I didn't think it worked that way.



MR. FERLEGER: Your Honor, an affidavit that we filed with the Court involves a boy who was on probation from Juvenile Court for truancy before he came to the hospital, and in his affidavit he explains that the doctor at the hospital wanted him to go to reform school, and it was made clear to him that he had a choice; to be deprived of his liberty in the mental hospital, or in reform school. And the behaviors are identical. It is just that a doctor puts a psychiatric diagnosis—

JUDGE BRODERICK: That is his affidavit.

JUDGE GIBBONS: Let's assume we take that as true, and take that there are such cases. Your position is that in no case should the juvenile be committed without a judicial proceeding. Let's assume that he—

JUDGE BRODERICK: He has an exception on that.

JUDGE GIBBONS: Except in the emergency, but that would be a short term commitment.

MR. FERLEGER: Your Honor, or in the voluntary situation. There are—

(17) JUDGE GIBBONS: Now let's take the voluntary situation by way of contrast.

How competent is a juvenile of 13 to make a decision to commit himself voluntarily? That is first.

Second, if we are talking about a judicial proceeding, do we have grounds, at least so far, for laying down a rule that the Guardian Ad Litem in that proceeding may not be the parent, which in effect, it seems to me that is going to have to be your position, that in every instance you are going to convert the commitment proceeding into an adver-

sarial proceeding between a Guardian Ad Litem, because the juvenile can't appear otherwise, and the parent.

MR. FERLEGER: Heryford v. Parker involved a situation where the 9 year old, according to the Court, was entitled to a Guardian Ad Litem other than the parent. In terms of the voluntariness of a 13 year old in that capability, there are situations at Haverford Hospital, as a deposition that has just been transcribed will indicate to you, where children are in the hospital and where the hospital thinks they should remain but the parent (18) who signed them in now decides to take them out, and under the law now, the situation where a hospital thinks a child should be there and the parent wants the child out, in that situation the parent can, and does, take the child out.

JUDGE GIBBONS: The State has a remedy. There are other statutes governing that situation. They can terminate parental rights. There are other steps that can be taken.

MR. FERLEGER: Or they can have the regular Section 406 civil commitment.

JUDGE GIBBONS: I am not concerned with that case because assuming that the hospital is acting for the child there are ample—

MR. FERLEGER: But there are other cases Your Honor, like one which I know where the child wants help, the child would love to sign into the hospital because the child is afraid of killing herself in this case, but the parents don't want to sign the papers. And in that situation you are telling the child that you have to run around to welfare agencies, or to the State authorities in order to get in.



JUDGE MASTERSON: . How would we handle (19) that?

MR. FERLEGER: The way it can be handled Your Honor is by permitting any person to apply for voluntary care in the hospital.

JUDGE MASTERSON: Regardless of age?

MR. FERLEGER: Right. The hospital would then make their evaluation of the need, and if there was a need for commitment then a person could stay, even if the parent decided that the child didn't need help.

You see, there is—

JUDGE GIBBONS: Of course you are going far afield. You can't contend that the inability of a juvenile to commit himself voluntarily is a due process violation.

MR. FERLEGER: That is an equal protection issue.

JUDGE MASTERSON: Or equal protection. Because follow that where it leads. It leads to us conferring by judicial decree all of the rights on children, maybe you draw the line at 7, maybe you wouldn't, that are now conferred on them by law at age 21, 18 in other states.

MR. FERLEGER: No. I think it is different (20) when it involves institutionalization, when it involves treatment for mental health problems.

JUDGE MASTERSON: Children can not be treated differently than adults, the theory is, in this setting. Then that means if it is true in this setting, it ought to be true in any other setting, and I don't think I am going to go that far. I am not prepared, by judicial decree, to say that 12 year olds are as mature as 18 or 21 year olds.

JUDGE GIBBONS: For example, would you go so far as to say that a 12 year old should be free to consent to an amputation?

MR. FERLEGER: I have been doing some research in the past couple of weeks on sterilization in juveniles in Pennsylvania, about which there is very little, almost no law.

In that kind of situation I would like, as I would in the hospital situation, some independent person to make that kind of decision.

In the hospital situation, if a child—

JUDGE GIBBONS: If the independent person designated, until the State takes steps under existing statutory authority, to substitute another guardian, is the patient's guardian. The parent—

(21) MR. FERLEGER: Your Honor, for the situation that Judge Masterson asked about, I am not saying that a child can come to the hospital and sit down and say, "I am staying here. You have to treat me." That is not what I am saying.

Under the law, and under what I am proposing, the hospital would have to make its own examination to determine if the child was mentally disabled.

JUDGE MASTERSON: It is a little inconsistent. You are willing, in effect, to take the hospital as the substitute guardian in the child voluntary setting, but not in the involuntary parental application setting.

JUDGE GIBBONS: If they are nonadversary in one, why are they not nonadversary in the other?



MR. FERLEGER: The reason Your Honor is that when it involves an involuntary commitment, when it involves saying to a child that you have done things and this means you are sick, and you have to stay here, that doctors in the hospital shouldn't be making that decision. When it involves a child saying, "I want to be here." Then the State doesn't have any authority—

(22) JUDGE MASTERSON: How about the situation where the child is angry at its parents and, you know, doees this to wound the parents and persuades the doctor, well, maybe the kid can use a little treatment for a week or two and now the parents can't get their own child back? That is a little frightening to me.

MR. FERLEGER: Well, it is. The thing, though, that is more frightening to me is the parents who are angry at the child and take the child to the hospital.

JUDGE MASTERSON: Right. That is why I would like to get some of the real facts. I think, by and large, most parents discharge their parental functions with respect to their children in a responsible way. I think most parents love their children and behave in that fashion. I think that this whole lawsuit is about very very few parents who either, through ignorance or their own emotional problems, abuse the parental right and attempt to have State agencies reinforce their abuse. I don't think there are very many of those cases and I wouldn't want to upset the whole parent-child relationship in this, and in other respects simply (23) because there may be a few cases where this abuse occurs.

So I think we would like to get some kind of factual record. When is that study going to be completed?

MR. FERLEGER: Well, the people who are doing the research have agreed with me that they will, even though they are not complete with the study, they will provide answers and statistics from the study even before it is completed. I will be getting an affidavit—

JUDGE MASTERSON: Let's talk about what kind of facts we want and how we could get them.

JUDGE GIBBONS: Before we go into that, let me ask this. Among the original plaintiffs, how many are still in Haverford?

MR. FERLEGER: There is one person that the State said the patient was on a short term leave. I am not sure, as of now, whether or not he is still at the hospital.

There is another plaintiff who I am near certain is still in the hospital.

JUDGE GIBBONS: Well, we can hardly act on near certainty. If there is nobody in the (24) hospital, a good part of your case is moot, particularly your contentions with respect to voluntary admission, because none of those plaintiffs are seeking voluntary admission.

Now that brings up the next question. These are all children, minors, and there is at least some indication that some of them may be actually, or potentially, unstable. It seems to me that we have to get some information about whether or not they would be adequate class representatives. We can't proceed even with a class suit without a live plaintiff.

JUDGE MASTERSON: And we have a preliminary threshold question; can someone who is not Sui Generis



be a class plaintiff, or would we not have to appoint, or have you go to the local Court to appoint a guardian?

MR. FERLEGER: Your Honor, my understanding of the law in this regard is that the Federal Court would apply for this purpose, for competence, the State law. We have brought this action as a complainant case as the next friend of the plaintiffs.

JUDGE MASTERSON: How do you get to be the (25) next friend. It is usually the parent, and if not the parent, if you are representing the person of a minor, you have to be appointed guardian of the person.

MR. FERLEGER: For incompetence I believe Pennsylvania State Law, and I believe for minors, permits the person to choose—

JUDGE MASTERSON: The parents of someone in Loco Parentis, how do you get to be in Loco Parentis?

MR. FERLEGER: According to Pennsylvania law, a person in Loco Parentis does not have to be appointed by the Court. A person in Loco Parentis—

JUDGE GIBBONS: How do you get to be that person?

MR. FERLEGER: Well, in a number of ways: One way being that my job, my relationship with Haverford State Hospital, it happens to be the defendant, is to represent patients there, to act for patients.

JUDGE GIBBONS: First of all, if you have a connection with Haverford State Hospital in some official capacity, if I were sitting in the Orphans' (26) Court that would rule you out as a guardian.

MR. FERLEGER: Your Honor, not in that sort of official capacity. My connection with Haverford State Hospital is to provide independent legal advocacy—

JUDGE GIBBONS: All right. Let's assume that, and let's assume you would qualify as such a person. You have not, at least on the papers I have seen, we have individual plaintiffs acting thus far in their own right. It seems clear from the papers before us that as to some of those plaintiffs their case is now moot.

As to the others, their case may not be moot, but we need a good deal more guidance than we now have as to whether or not they are adequate class representatives, and also whether or not they can proceed without a guardian of their person. And if they can not, who that guardian should be, and if such a guardian is appointed can he also act as a class representative? There are potential conflicts too that would concern me that grow out of the potential difference in the problems of the 17 year old as contrasted with the 13 or the 6 year old. And query, if the same person could act for (27) all of those people.

MR. FERLEGER: In terms of the class representative adequacy I would like to make a couple of points.

First, that there have been a large number of cases, the most well-known recent one is the Wyatt v. Stickney case in Alabama; persons who are in mental hospitals, in person, you don't have to be an incompetent to be a patient, wherein patients have been class representatives. In terms of the adequacy of the factual background, I believe that the Interrogatories which we seek to have answered, one of the reasons we asked this portion of them was to find out what the class consists of in Pennsylvania.



We have asked the State to provide the names and the situations of the juveniles who are now incarcerated against their will. If the Court knew that, the Court would be in a better position to determine the adequacy of our representatives.

JUDGE MASTERSON: All right. Well, that raises a question that I guess we might as well address ourselves to, to the Commonwealth's motion—

(28) MR. FERLEGER: I didn't hear you.

JUDGE MASTERSON: The Commonwealth's resistance to answering your Interrogatories.

Are you continuing to resist answering those Interrogatories?

MR. ROTH: Yes, Your Honor. We are continuing to resist answering for all the institutions.

JUDGE MASTERSON: Why? Simply because it is such a big job?

MR. ROTH: Not only that, but there really has been no determination on our Motion to Dismiss. Notwithstanding that, and not to mislead anyone, we informed Mr. Ferleger he may go to the various institutions and obtain the information as well as we have gone ahead and received all the materials from our State schools and hospitals.

Now Mr. Ferleger has defined facilities as including day care centers and we have over 600 facilities in the State. We are going throughout the entire State having the information collected. We did furnish him with the Haverford material at the outset, and we are not going to deny furnishing him with this material, but before we

want to go on, and if we need to be corrected we will, but before (29) we went to proceed and continue this burdensome procedure, we wanted to know if our Motion to Dismiss would be granted.

JUDGE GIBBONS: I think we can assume; that without a record we are not going to grant your motion, except to this extent: I think, and frankly you don't even want this relief, I question whether the hospital is a proper party. It is not a person within the meaning of Section 1983. It may be that because of some features of Pennsylvania law it may be suable under Federal jurisdiction or you may be able to find a State remedy that would be picked up 420's C Section 1988. But on the surface it would look as if the hospital would be entitled to get out, because it is not a person. That would not end the lawsuit, of course, and I don't know how interested the State would be in gaining that small technical advantage.

But as far as the rest of the lawsuit I think you can assume that we will want to make a record before we decide whether or not to dismiss.

MR. ROTH: Your Honor, if I may, we have been talking about the proposed regulations and they were to be effective on May 1. However, we received (30) several comments about these regulations, and the main comment was, how do we provide for mentally retarded children in the sense of what opinion can be forthcoming for them. So we have amended our regulations which I am prepared to give you a copy of, and we are going to publish these in the Bulletin to take effect July 1.

In addition to what we already had in the regulations published March 24th, we have provided that after



six months a review will be taken, an evaluation of those proposals, and if necessary we will hold public hearings. We don't want to mislead anyone into thinking that by publishing these we are afraid of this lawsuit, and we are trying to resolve it that way. We are most concerned, above all, of the fact of stripping parental rights, and that is our major concern in this lawsuit.

JUDGE GIBBONS: Well, it obviously is ours, as you can see from the questions that have been asked.

At the same time I think on the surface some post admission procedure along the lines that you proposed in the regulations seems singularly appropriate. I don't know what the amended (31) regulations will provide with respect to the mentally retarded, or with respect to the under thirteens, which are not dealt with in the proposed regulation.

One possible approach would be that at each facility a standing Guardian Ad Litem, someone in the nature of a guardian, be appointed to review automatically after a certain length of time. And by suggesting that I don't even suggest that it is a good idea because we don't have enough facts.

MR. FERLEGER: Your Honor, I agree completely in terms of the facts, one, that is one reason why we pressed for the Interrogatories, because I don't have at this point, and the Court does, a list of the procedures that are used for juveniles.

JUDGE GIBBONS: Will there be any difficulty about that now that you know we are not going to, at least at this stage, grant your motion?

MR. ROTH: No, Your Honor. What we can do is go ahead with the State schools and hospitals.

With regard to day care centers and—

JUDGE MASTERSON: Well, wait. Are you (32) challenging procedures relating to the day care centers, and schools, or is this confined to mental hospitals?

MR. FERLEGER: I am not asking for procedures in terms of day care centers. I think Mr. Roth is misreading the State law definition for facilities. What we are asking for is for information about commitments to institutions which deal with mentally disabled people.

JUDGE GIBBONS: Well now, can you at least limit it to residential institutions?

MR. FERLEGER: Certainly.

JUDGE GIBBONS: There are mental health facilities that are on an outpatient basis.

MR. FERLEGER: Certainly.

JUDGE MASTERSON: All right. Now what does that mean in terms of the size of the job? How many residential mental institutions do we have in this State?

MR. ROTH: That would be impossible for me to answer. I can find out. One thing you have to realize—

MR. FERLEGER: I think that Mr. Roth's partial answer to Interrogatories gave us a complete (33) list of inpatient facilities.

MR. ROTH: You are talking about residential units.

JUDGE MASTERSON: We are limiting this to residential. That is what I want to know. How many inpatient residential mental hospitals do we have in the Commonwealth?



JUDGE BRODERICK: It can't be any more than 25.

MR. FERLEGER: It is certainly less than what we have here. Some of the inpatient facilities are regular hospitals with 5 to 10 beds. So some of them are only emergency. We are not talking about them.

JUDGE MASTERSON: Why don't you and your opponent here sit down and work out a schedule for the production of the information you need that is relevant to this case?

MR. FERLEGER: Certainly.

JUDGE MASTERSON: And you can be advised that the Court will require you to answer the information with respect to inpatient residential mental institutions only at this stage. Okay?

MR. FERLEGER: Certainly.

(34) JUDGE MASTERSON: Well, that seems to be the first step. Then the next step is that we would like to be briefed on the legal questions we have raised. The capacity of any of these minors to bring this action; the capacity of them to be "class representatives", the question of whether a Guardian Ad Litem should be appointed and who appoints them. And what else?

JUDGE GIBBONS: And how the class should be defined and whether or not subclasses, based on age or condition, or other considerations possibly even based on sex of the juvenile might be appropriate. I think they should certainly be brought before us on a motion to determine the class.

JUDGE MASTERSON: Yes. Right.

JUDGE GIBBONS: And with appropriate papers and with testimony, if necessary, if there are contested facts.

JUDGE BRODERICK: I am concerned about the Interrogatories, the answers. I am not so sure that I know how broad the question was, but I would certainly want to know what the present procedures are for the admission of children into those inpatient institutions, not just the inhouse (35) procedures as to how they get out, but I also want to know how they get in.

MR. FERLEGER: Those are covered by our questions 7 and 8. They are not answered.

JUDGE BRODERICK: They are covered in the Interrogatories?

MR. FERLEGER: Yes, Your Honor.

JUDGE BRODERICK: All right.

JUDGE MASTERSON: Do you need any more guidance from us right now?

MR. FERLEGER: I am not quite clear Mr. Roth has agreed to answer questions 7 and 8 involving the procedures.

JUDGE MASTERSON: He has been directed to answer them with respect to all inpatient residential mental institutions. Now if he has to be hit over the head with a brick that can be done too.

MR. ROTH: I am certain that is not necessary. I have just one question.

In bringing out the evaluation of these people perhaps it would also be worthwhile to know whether or not



the juvenile, when admitted to the institution, number one, had the capacity to even exercise the judgment to reject institutionalization. (36) I think that is a very severe question.

JUDGE MASTERSON: It is a very serious question.

JUDGE GIBBONS: That is one of the reasons why we have to get into subclasses.

MR. FERLEGER: Your Honor, I want to make one final point to your comments before, Judge Masterson.

Involving the general procedure in Pennsylvania which covers adults, which is, in fact now a situation in which the Courts do review every situation where an adult is put into a hospital against his will—

JUDGE MASTERSON: I find that really hard to believe.

MR. FERLEGER: I know. That is why I wanted to explain. Maybe I can get you some information of the number of commitments involved because I am not really clear whether it would really be any burden on the Master, the Judge who holds the hearing to hold two or three more hearings a week for three 17 year old kids.

JUDGE MASTERSON: We will get into the statistics. You will develop it here.

(37) MR. FERLEGER: That is correct, Your Honor.

JUDGE MASTERSON: All right. Now the question is scheduling. How long will it take to get the factual information together?

MR. ROTH: I would assume that is going to take a good deal of time.

JUDGE MASTERSON: Such as what?

MR. ROTH: I would like to request 90 days.

MR. FERLEGER: Your Honor, they have had the Interrogatories since 1972, since the end of December, 1972. In their memorandum they told the Court that we are working on getting the information together. I think if they have been working on it for 4 or 5 months—

JUDGE GIBBONS: Well, as a practical matter 45 days would get into the summer in any event. How about August 1st so that he can come back to the Court with any necessary discovery motions, and I certainly hope there won't be any during the month of August.

JUDGE MASTERSON: All right.

MR. ROTH: I will try my very best. As (38) you can understand the State procedure and going through your regional deputies and superintendents, including all inpatient residential centers, it is vast, and not only doing that but going back over those who already submitted information and requesting whether or not the juvenile rejected his admission and also whether or not he was capable of understanding his—

JUDGE MASTERSON: Well, it is going to be a big job for some people. It seems to me that all we are going to need is the statistical readout; how many of them objected, how many, in the opinion of the institution, had the capacity to object rationally, and et cetera.

MR. FERLEGER: Your Honor, what you have asked for, and the Court needs in terms of Judge Broderick's procedures, is the precipitated behaviors, the kind of things these juveniles were doing that brought him here.



JUDGE GIBBONS: That is a confidentiality problem there. If you are looking for that information for statistical purposes only, I assume you would have no objection to maintaining the confidentiality of identity.

(39) MR. FERLEGER: Of course not.

Could I ask the Court, since Mr. Roth has said he already has some information, especially on the policies questions that Judge Broderick asked about, could Mr. Roth give us, in the near future, the information he has now?

JUDGE MASTERSON: He should give you now whatever he has and keep feeding to them whenever you get it so there isn't any unnecessary delay.

Now that also gives you the same amount of time to supply us with the briefs we requested on the legal questions. So you have a big job ahead of you, both of you.

MR. FERLEGER: Your Honor, if the information is to be provided by August 1st, I would suggest about two weeks after that, if there is no more discovery, for the briefs which would discuss the case.

JUDGE GIBBONS: That is fine.

JUDGE BRODERICK: Fine.

JUDGE MASTERSON: Is August 15th a weekday?

JUDGE GIBBONS: August 15th is a Wednesday.

Now I think I would just like to add a (40) word on this discovery program about my own attitude on this.

We can only act in the context of a lawsuit, but in fact what we are being asked to do is to examine legislation and possibly to legislate. And I think that both of you should enter into some sort of a cooperative effort to get us the kind of information that you would give to a legislative committee studying this problem. We really need help. I frankly say I am very troubled by this case and I would not want, considering the nature of the problem, to see it go forward with a lot of Mickey Mouse on discovery.

MR. ROTH: We are at a loss too in the sense that we don't know what else could be done other than giving the plaintiffs the relief they seek by providing hearings prior to commitment of juveniles, and we can't do that. We wouldn't want to strip parental power that way, and we have tried to implement additional safeguards which we feel to be acceptable. I am willing to discuss with Mr. Ferleger any other recommendations he would like to include in the amended proposals and perhaps we could solve the case that way, but my understanding (41) at this point is that nothing short of the relief he seeks will be acceptable to him.

JUDGE GIBBONS: Well, at that point if you can agree on 70 per cent of the problem, and you have to come back to us and take testimony on the balance, we will hear what the experts have to say.

JUDGE MASTERSON: Yes.

Incidentally, on that subject we expect, on the testimonial phase of the case, to have real experts advise us, because it is a very very delicate, sensitive problem. All right.

MR. ROTH: Yes, sir.



MR. FERLEGER: Certainly.

JUDGE GIBBONS: All right. They are scheduled to file their papers August 15th. We will determine a hearing date after we get your papers, hopefully in September.

MR. FERLEGER: Thank you.

MR. ROTH: Thank you, Your Honor.

MR. O'SHEA: All rise.

(Whereupon the Court recessed.)

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted]

# INCARCERATED JUVENILES—WHY? THE MENTAL INSTITUTIONALIZATION OF JUVENILES IN PENNSYLVANIA

*An Analysis of Data Submitted by Defendants in Response to Interrogatories by Plaintiffs*

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## I. INTRODUCTORY COMMENT

This is a review and content analysis of facts of record in this case regarding the reasons juveniles are institutionalized in mental facilities in Pennsylvania. The indented and other quotations, unless otherwise indicated, are the reasons given by the *institution and doctors themselves* for the confinement of the juvenile.

## II. EXTENT OF INFORMATION

On September 15, 1973, Plaintiffs filed an analysis similar to the one below based upon information regarding



state institutions for the retarded. Since that time, the Defendants have provided information regarding juveniles in the twenty state mental hospitals and this new data has been incorporated into this study.

While—as the tables below indicate—the Defendants have failed to provide all the information this Court required, enough is presented to provide a substantial factual basis for the proceedings in this matter.

The raw material analysed below is in the record of the Court and includes a survey of all mental facilities in Pennsylvania operated or licensed by the Defendant Department of Public Welfare. Data was collected on the admissions of juveniles, the reasons for such admission and the relationship between the applicants and the juveniles.

## III. WHAT IS SHOWN—IN GENERAL

The record depicts numerous private tragedies and gross personal and medical difficulties in which it is appropriate for the juvenile to be maintained in an inpatient residential setting.

However, as detailed below, there are many cases in which it is shocking that institutionalization was resorted to or in which it was done not to benefit the child but to benefit the parent or parents. There is little support here for a blanket presumption of proper medical or parental action.

Many of the children in institutions are there because of difficulties adjusting to the norms of our society. The psychological term often applied is "Adjustment reaction of infancy and childhood"; this is attributed to the greater

fluidity of all behavior at this age and characterized by such symptoms as overactivity, inattentiveness, shyness, feeling of rejection, over-aggessiveness, timidity and delinquency.[1] Difficulty in school, problems with peers, drug usage, hostility, aggression, and temper tantrums are frequent reasons given for institutionalization of juveniles. The factual allegations supporting such descriptive conclusions are often in dispute and there is at present no procedure by which such disputes may be resolved so that institutionalization may be compelled on a fair basis.

Many children are committed to mental institutions for "delinquent" non-"insane" behavior, or because parents don't care, or simply because someone didn't know what else to do with them. The following reason given for commitment of a 17 year old male to Holidaysburg State Hospital is a sad comment on this situation:

> Mr. ———— was admitted to the Cresson State School and Hospital in July, 1965. In February 1971, he was admitted to the Western State School for an evaluation. He was found to have an I.Q. too high for residency in a state institution for the retarded. Despite the absence of psychotic symptomology, he was ordered admitted due to a long history of emotional deprivation and institutionalization during a critical developmental period of his life.

Six juveniles at Western State School and Hospital were committed under sections of the 1951 mental health law and nobody has bothered, in the seven years since the 1966 law was passed, to have proper commitments instituted. A more inexcusable fact is that Pennhurst

[1] Diagnostic and Statistical Manual of Mental Disorders (DSM II), American Psychiatric Association ( ).



State School and Hospital admits that four patients (Nos. 146 to 149) have "no commitment", in other words, the state has been holding these people with *no legal authority whatsoever*.

Although incomplete information often lists MR (mental retardation) as the reason for commitment for many persons, when one looks at the complete replies of Pennhurst (where all patients are retarded), one sees the actual behaviors which provoked institutionalization (*e.g.*, runaway, incorrigible, abusive, assaultive, self-destructive, impulsive).

In a large proportion of cases, it is not even the parent who initiates the commitment. A social welfare agency, a juvenile court, a relative or others, place dozens of juveniles in institutions "voluntarily".

It is clear that some screening process is necessary. There are some persons whose commitment is or may be justified under the law and some who ought not be committed. Neither the parents, the hospitals nor the welfare agencies are presently protective of the rights of these juveniles. The question before this Court is whether the "applicants" under Sections 402 and 403 plus the medical staffs are sufficient "screens" or whether the impartial court must step in.

The examples below indicate the miserable failure of the present state of affairs, the state of affairs which the Defendants herein ask this Court to allow to continue.

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## IV. BEHAVIOR SIMILAR TO DELINQUENT BEHAVIOR

Many parents and agencies have institutionalized children for behavior which, if brought to the juvenile court's

attention, would have required the due process protections of the Constitution; by using the mental health process, the parents were able to avoid a hearing:

> Runaway, incorrigible (Pennhurst, No. 402).
>
> Violent episodes (Polk, No. 13, 173).
>
> Hostile, attacked children, attempted to set home on fire (Polk No. 13,077)
>
> Robbed gas station (Mental Health Center of Carbon, Monroe, Pike Counties, No. M-0-0543).
>
> Stole truck, car (Mental Health Center of Carbon, Monroe, Pike Counties, No. M-0-1210).
>
> Member of gang which participated in Robbery (Thomas Jefferson University Hospital No. 360233).
>
> Stealing (Northwestern Mental Health Center, No. 628).
>
> Involved in an altercation with a 10 year old girl whom he chased and struck (Ailentown State Hospital No. 25380).
>
> Fire setting (Northwestern Mental Health Center, Inc. No. 620).
>
> Delinquent Behavior (Northwestern Mental Health Center, Inc. No. 637).
>
> Fire setting (Northwestern Mental Health Center, Inc. No. 61).
>
> Runaway (Northwestern Mental Health Center, Inc. No. 188).
>
> Arson (Fairmount Farm, No. 16380).
>
> Runaway (Fairmount Farm, No. 16187).
>
> Firesetting, stealing (Western, No. 281).
>
> Runaway, truancy, delinquent behavior (Western, No. 288).



For similar reasons, the courts commit juveniles to these *same institutions,* for example:

> Aggressive behavior towards family. Refusal to attend school.
>
> Excessive demands of attention at home. (Western, No. 285).
>
> Charged with arson and delinquency (Eastern Penna. Psychiatric Institute).

If the applicants for "voluntary" commitment had chosen to bring the above behaviors to the attention of the juvenile court, due process hearings would have been afforded the minors. In Re Gault, 387 U.S. 1 (1966); Kent v. United States, 383 U.S. 541 (1966); In Re Winship, 397 U.S. 358 (1970). The rehabilitative institutionalization of the juvenile court process requires such hearings. However, since the applicants chose to bring these juveniles to the mental hospital, rehabilitative institutionalization was accomplished without any process at all.

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## V. COMMITMENT FOR BENEFIT OF PARENT(S)

These instances are the most disturbing for they prove how the mental health facilities cooperate with parents and relatives in doing what Judge (now Chief Justice) Burger called

> "farming" out their kindred into mental institutions for motives not always worthy.
>
> Kent v. United States, 401 F.2d 408, 416, footnote 4 (D.C. Cir. 1968) (dissenting).

For example, one child wound up at Polk for an "interim placement while family was on vacation." No. 13,212. A mother placed her child at Western simply

because "Father out of household in the military." No. 144. One juvenile's "hyperactivity interfered with the routine of household and disturbed family members." Western, No. 15.

A newly widowed father was able to place a youngster at Western because he allegedly was "unable to care for child." No. 67. The same hospital accepted a child from a mother because of "desertion of father." No. 131.

In another striking case, a mother and father who had emotional difficulties themselves institutionalized their child at Polk because they held the "problems of the child . . . responsible for their emotional adjustment." No. 12,482.

One institution accepted a juvenile because: "Difficult to care for Loretta and her presence confines the parents in the home." Western, No. 73. A boy named Joseph left "no free time for mother." Western, No. 13. If these are proper reasons for depriving someone of liberty, then the state could summarily lock up almost every child that parents present at the hospital doors.

In numerous cases, children are the ones who are forced into treatment when it is the *family* as a whole which, according to the hospitals, has the problems. See Henry, *Pathways to Madness* (1973); Esterson and Laing, *Sanity, Madness and the Family* (1964):

> Family Problems (Philhaven Hospital, No. 5647)
>
> Family Conflicts (Institute of Penna. Hospital, No. 94-94-33)
>
> Family problems, needed separation from the family (Wernersville State Hospital)



In similar cases, it is the least powerful member of the family—the child—who is shunted off to the mental hospital when the parents decide they cannot or do not wish to deal with the situation:

> Unmanageble at home, attitude of bold indifference, resents all discipline, compulsive eating (Allentown State Hospital, No. 25741)
>
> Problems with family (Philhaven Hospital, No. 5692)
>
> Began to have trouble handling his angry and hurt feelings toward his parents. Took these feelings to school with him. (Allentown State Hospital No. 25520)
>
> Runaway, Conflict with Parents (Institute of Penna. Hospital No. 94-93-74)

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## VI. "WHICH CHILD DO WE COMMIT?"

Families with more than one child may use the mental hospital as a way of reducing the number of family members. For example,

> Physical burden on mother who has three additional children. (Western No. 36).
>
> He is one of three mentally retarded in the family. Coping with this problem is simply too much for the family. (Polk No. 13,103).

When a decision is being made as to which, if any, of three children is to be deprived of liberty, is this a medical decision? Will there be any protection for the child whose "number is up"?

## VII. JUVENILES COMMITTED BECAUSE OF PARENT'S PROBLEMS

In a suprising number of cases, there was nothing serious reported wrong with the child but a parent's problem caused a commitment. A few outstanding examples:

> Became argumentative and wanted to stay out of school. Patient's mother overdosed and was hospitalized. Patient then had to be hospitalized. (Warren State Hospital).
>
> Neglect, Social Deprivation (Stillmeadow Home for Exceptional Children No. 1145).
>
> Neglect, Unstable home environment (Stillmeadow Home for Exceptional Children No. 1138).
>
> Mother has tuberculosis. (Western, No. 129).
>
> Emotional instability of mother. (Western, No. 127).
>
> Hospitalization of mother is apparent reason for admission. (Polk No. 11,985).
>
> No serious behavior problem; admitted due to parent's inability to provide a satisfactory home environment. (Laurelton No. 42).

A court hearing could have explored the facts in these cases, and found a less restrictive alternative which would not punish or "treat" the child for a parent's difficulty.

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## VIII. IMPROPER BASIS FOR INSTITUTIONALIZATION

Despite Levy v. Louisiana, 391 U.S. 68 (1968), and similar cases, these were the sole reasons Western gave for the commitment of three persons to that institution (all signed in "voluntarily" by the mother):



> Quite active and destructive. Illegitimate. (No. 226).
>
> Sometimes hyperactive. Illegitimate. (No. 228).
>
> Illegitimate. Inadequate mother. (No. 227).

Polk readily accepted a young boy for this rather unusual reason:

> "He has no playmates, planned activities, exercise. Presently he does nothing except sit in school and in front of the TV at home," stated the parents. (No. 12,836).

Although a child could have been receiving "training for autonomy," the parents wanted only "services and sheltering" so one young woman remains at Polk without such training. No. 13,221. The only reason given for one patient is "Admitted to Polk State School and Hospital for educational purposes." No. 12,811; state law now requires public schools to provide education to all, including the retarded.

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## IX. INSUFFICIENT BASIS FOR INSTITUTIONALIZATION

### *Physical Problems Alone*

Three children were committed to mental hospitals because of physical ailments. At Saint Francis' Hospital one child was committed for ulcerated colitis (No. 13-58-69); another for psychosomatic complaint (No. 11-81-06). A third child was put in the Institute of the Pennsylvania

Hospital for weight loss (No. 94-88-05). A physical ailment alone is an insufficient reason to put an individual in an institution.

*School Problems Alone*

There are 5 children in Saint Francis' Hospital for not going to school. This list is as follows:

School phobic (No. 12-87-29).

School phobic (No. 12-80-40).

School phobic (No. 11-17-68).

Non-school attendance (No. 14-57-10).

Non-school attendance (No. 14-18-89).

Not going to school hardly seems sufficient reason to commit a child to a mental institution.

*Drugs*

It is understandable that when a parent finds his child is using drugs he becomes concerned and looks for help with the problem. Under the existing laws concerning juvenile commitment it is too easy for a parent or guardian to evade their responsibilities by having the child commited. Drug usage alone is not a sufficient reason to commit a person to a mental institution unless the facts and alternatives have been considered by a court. A partial list of juveniles committed for drug related activities is as follows:

Mental Health Center of Carbon, Monroe & Pike Counties:

Overdose (No. M-0-1174)

Overdose (No. M-0-1165)

Drugs (No. Z-0-1104)



McKeesport Hospital:

Medical overdosage (No. S.K.)
Medical overdosage (No. R.M.)
Medical overdosage (No. R.W.)
Medical overdosage (No. R.K.)
Medical overdosage (No. T.G.)
Medical overdosage (S.C.)
Medical overdosage (T.S.)

Fairmount Farm:

Drugs (No. 16155)

Drugs (No. 16147)

Drugs (No. 16027)

Institute of the Penna. Hospital:

Drugs (Nos. 94-90-72, 94-95-23, 94-93-00, 94-94-92, 94-93-52, 94-91-42, 94-95-32, 94-95-57, 94-91-87)

One juvenile has even been committed for a "*fake* drug overdose." St. Francis General Hospital, No. 11-85-22).

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## X. ILLEGALITY OF GENERAL ADMISSIONS

Mental health facilities are required by the mental health act to receive patients *only* pursuant to the statutory provisions of the statute. However, 11 facilities for which data was provided admitted that, rather than using the proper provisions of the law, they accept mentally ill juveniles as "general admissions."

This illegal method of commitment denies to juveniles the presently scant protections of Sections 402 and 403

and also denies them the protection of the new regulations the state has adopted.

By going outside the mental health act, the patients' rights (Section 423) need not be enforced and other rights are denied, e.g. the right to be discharged when treatment is completed (Section 418), the right to leaves of absence (Section 419), the right to review by the Department (Section 420).

These are the facilities which presently act in this improper manner:

Happy Hill
Don Guanella School
St. Mary of Providence School
Ivy Mansion for Exceptional Children
The Evans School
Clifford Nursing Home
Camphill Special School Inc.
Greenwich Home for Children
Refuge Home for Children
Merry Acres
Pleasant Manor Inc.

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## XI. CONCLUSION

The above data show that special, personal and legal judgments enter into decisions to institutionalize juveniles; by no means is it purely medical decision. Indeed, where the medical people are involved, as in all the cases cited above, abuses still occur.

The wisdom of allowing and requiring courts to determine whether someone should be institutionalized is



brought into clearer focus by the goings-on which the present mental health system permits. As the tables below, especially Table 3 indicate, it would be no great burden on local courts to hold hearings for the small number of juveniles admitted each year. For example, the county in which Polk State School and Hospital is located would have had only 33 additional hearings last year; Whitehaven patients would have required only 87 hearings.

When facts are disputed and careful judgments must be made, especially where objections are made (even though there is presently no right to object), and where adverse interests are involved, there is no reason shown in the data above why juveniles should be denied the same due process as adults get in the mental health setting and as other juveniles get in the juvenile court context.

Respectfully submitted,

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March 26, 1974

## TABLE 1 -- "VOLUNTARY" COMMITMENTS AND APPLICANT CATEGORY

| Name of State School and Hospital | Type of Commitment 402 | 403 | Other | APPLICANT FOR COMMITMENT Parent(s) | Welfare or Social Service Agencies | Court, Juvenile Court, Judge | Other family Members* | Misc. | Not Given** |
|---|---|---|---|---|---|---|---|---|---|
| Polk | 341 | 0 | 0 | 300 | 39 | 0 | 1 | 1 | 1 |
| Ebensburg | 619 | 0 | 0 | 595 | 24 | 0 | 0 | 0 | 0 |
| Pennhurst | 109 | 1 | 0 | 98 | 5 | 1 | 2 | 0 | 4 |
| Cresson | 238 | 0 | 2*** | 209 | 25 | 0 | 5 | 1 | 0 |
| Selinsgrove | 225 | 0 | 0 | 196 | 7 | 0 | 3 | 0 | 20 |
| Western | 291 | 8 | 0 | 267 | 7 | 4 | 5 | 11## | 5 |
| Laurelton | 70 | 4 | 0 | 58 | 6 | 0 | 2 | 1 | 0 |
| Whitehaven | 169 | 0 | 0 | 123 | 8 | 0 | 1 | 1 | 36 |
| Hamburg | 214 | 0 | 0 | ?= | ? | ? | ? | ? | ? |

* "Other family members" include grandparents, uncles, aunts, brothers.
** There is no explanation for the facilities' so frequently leaving blanks in their replies.
*** These two persons are transfers from other facilities; they are listed as "voluntary" but no applicant with appropriate legal section is given.
## These 11 persons' applicants are listed as "Entrustment Agreement."
= No detailed information was provided by Hamburg State School and Hospital.

**All entries refer to the number of cases involved.**

TABLE 1. -- "VOLUNTARY" COMMITMENTS AND APPLICANT CATEGORY

| Name of State School and Hospital | Type of Commitment 402 | 403 | Other | APPLICANT FOR COMMITMENT Parent(s) | Welfare or Social Service Agencies | Court, Juvenile Court, Judge | Other family Members | Misc. | Not Given |
|---|---|---|---|---|---|---|---|---|---|
| Allentown | 73 | 9 | 0 | 19 | 2 | 0 | 1 | 0 | 60 |
| Hollidaysburgh | 0 | 3 | 0 | 2 | 0 | 0 | 0 | 1 | 0 |
| Harrisburg MH & R Center | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| Somerset | 4 | 16 | 4 | | | | | | 20 |
| Fairview | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Philadelphia | 4 | 0 | 1 | | | | | | |
| Warren | 0 | 5 | 0 | | | | | | |
| EPPI | 17 | 2 | 0 | 15 | 4 | 0 | 0 | 0 | 0 |
| Norristown | 14 | 4 | 0 | 16 | 0 | 0 | 0 | 2 | 0 |
| Torrance | 0 | 3 | 0 | 2 | 0 | 0 | 1 | 0 | 0 |
| Wernersville | 33 | 0 | | | | | | | |
| Haverford | 10 | 113 | 0 | | | | | | 123 |
| Retreat | 0 | 4 | 0 | 3 | 0 | 0 | 1 | 0 | 0 |
| Harrisburg St. Hosp. | 9 | 6 | 0 | 8 | 2 | 0 | 1 | 4 | 0 |
| Mayview | | 1 | | | | 1 | | | |

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## TABLE 2 -- COURT COMMITMENTS AND APPLICANT CATEGORY

| Name of State School and Hospital | Type of Commitment 406 | Not Given** | Other | APPLICANT FOR COMMITMENT Parent(s) | Welfare or Social Service Agencies | Court, Juvenile Court, Judge | Other Family Members* | Misc. | Not Given** |
|---|---|---|---|---|---|---|---|---|---|
| Polk | 18 | 0 | 0 | 1 | 7 | 9 | 0 | 1[a.] | 0 |
| Ebensburg | 12 | ? | ? | ? | ? | ? | ? | ? | 12 |
| Pennhurst | 44 | 3 | 3[b.] | 34 | 4 | 1 | 0 | 0 | 11 |
| Cresson | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Selinsgrove | 3 | 0 | 0 | 2 | 1 | 0 | 0 | 0 | 0 |
| Western | 6 | 0 | 6[c.] | 2 | 3 | 4 | 0 | 1[d.] | 1 |
| Laurelton | 6 | 0 | 0 | 4 | 1 | 0 | 0 | 1[e.] | 1 |
| Whitehaven | 2 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 |
| Hamburg | 20 | 0 | 0 | 16 | 2 | 0 | 2 | 0 | 0 |

* "Other family members" include grandparents, uncles, aunts, brothers.

** There is no explanation for the facilities' so frequently leaving blanks in their replies.

a. The petitioner was the Superintendent of Polk.

b. These were 3 transfers under Section 416.

c. These 6 were under the 1951 law.

d. The County Mental Health Administrator.

e. "Deputy Administrator of Juveniles and Misdemeanants."

All chart entries refer to the number of cases involved.

TABLE 2a -- COURT COMMITMENTS AND APPLICANT CATEGORY

| Name of State School and Hospital | Type of Commitment 406 | Not Given | Other | APPLICANT FOR COMMITMENT Parent(s) | Welfare or Social Service Agencies | Court, Juvenile Court, Judge | Other family Members | Misc. | Not Given |
|---|---|---|---|---|---|---|---|---|---|
| Allentown | 3 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 0 |
| Hollidaysburg | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| Harrisburg MH & R Center | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Sommerset | 1 | 0 | 0 | | | | | | 1 |
| Farview | 0 | 0 | 4 | 0 | 0 | 3 | 0 | 0 | 1 |
| Philadelphia | 7 | 0 | 0 | | | | | | |
| Warren | 22 | 0 | 0 | | | | | | |
| EPPI | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| Norristown | 13 | 0 | 0 | 4 | 0 | 1 | 0 | 8 | 0 |
| Torrance | 3 | 0 | 0 | 0 | 0 | 3 | 0 | 0 | 0 |
| Wernersville | 3 | 0 | 0 | | | | | | |
| Haverford | 24 | 0 | 31 | | | | | | 55 |
| Retreat | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |
| Harrisburg St. Hosp. | 10 | 0 | 0 | 3 | 4 | 0 | 0 | 3 | 0 |
| Mayview | | | | | | | | | |
| Woodville | 8 | 0 | 0 | 0 | 0 | 7 | 0 | 0 | 1 |







TABLE 3

NUMBER OF JUVENILES ADMITTED DURING 1972 TO FACILITIES

| Name of State School and Hospital | TYPE OF COMMITMENT 402 | 403 | 406 | Not Given* |
|---|---|---|---|---|
| Polk | 33 | 0 | 0 | 0 |
| Ebensburg | ? | ? | ? | all |
| Pennhurst | 11 | 0 | 30 | 0 |
| Cresson | ? | ? | ? | all |
| Selinsgrove | ? | ? | ? | 19 |
| Western | 55 | 3 | 2 | 0 |
| Laurelton | 29 | ? | ? | 2 |
| Whitehaven | 87 | 0 | 2 | 0 |
| Hamburg | 15 | 0 | 3 | 0 |

* There is no explanation for these omissions in the data supplied by Defendants.

TABLE 3a

NUMBER OF JUVENILES ADMITTED DURING 1972 TO FACILI[illegible]

| Name of State School and Hospital | TYPE OF COMMITMENT 402 | 403 | 406 | Not Given |
|---|---|---|---|---|
| Allentown | 65 | 23 | 2 | |
| Norristown | 17 | 11 | 15 | |
| Hollidaysburg | 0 | 2 | 1 | |
| Sommerset | {28} | | 0 | |
| Farview | 0 | 0 | 0 | 0 |
| Philadelphia | 9 | 2 | 4 | |
| Harrisburg MH & R Center | 0 | 1 | 0 | 0 |
| Warren | 4 | 0 | 12 | 0 |
| EPPI | | | | |
| Torrance | 0 | 4 | 2 | 0 |
| Wernersville | 12 | 0 | 3 | 0 |
| Haverford | 10 | 113 | 24 | 0 |
| Retreat | 3 | 1 | 1 | 0 |
| Harrisburg State Hospital | 7 | 13 | 14 | 0 |
| Mayview | | | | |
| Woodville | 4 | 20 | 7 | 0 |



TABLE 4

OBJECTIONS TO TREATMENT *

| Name of State School and Hospital | Objected at or after Commitment | Capacity to Object## Yes | No |
|---|---|---|---|
| Polk | 0 | -- | -- |
| Ebensburg | ?** | ? | ? |
| Pennhurst | 0 | -- | -- |
| Cresson | ? | ? | ? |
| Selinsgrove *** | 15 | 52 | 3 |
| Western | 15 | 6 | 8 |
| Laurelton | 7 | 3 | 4 |
| Whitehaven | ? | ? | ? |
| Hamburg | 0 | 0 | 0 |

* All the data here are questionable both in terms of their incompleteness and the fact that the replies arefrequently qualified by such terms as "no objection on the record" or "don't know."

** The question marks ("?") indicate no reply by the facilities.

*** Most Selinsgrove patients, except for those tallied here, are considered severely or profoundly retarded.

## The capacity to object is determined solely by the facility without any reported judicial determination of incompetency for that purpose.

TABLE 4a

OBJECTIONS TO TREATMENT

| Name of State School and Hospital | Objected at or after Commitment | Capacity to Object Yes | No | Not Given |
|---|---|---|---|---|
| Allentown | 16 | 1 | 15 | 0 |
| Hollidaysburg | 0 | 0 | 0 | 0 |
| Harrisburg MH & R Center | 1 | 0 | 1 | 0 |
| Sommerset | 1 | 1 | 0 | 0 |
| Farview | 0 | 0 | 0 | 0 |
| Philadelphia | | | | |
| Warren | 27 | 0 | 27 | 0 |
| EPPI | | | | |
| Norristown | 16 | 4 | 12 | 0 |
| Torrance | 0 | 0 | 0 | 0 |
| Wernersville | 10 | 7 | 1 | 2 |
| Haverford | | | | |
| Retreat | | | | |
| Harrisburg State Hospital | 16 | 3 | 10 | |
| Mayview | | | | |
| Woodville | 16 | 10 | 6 | 0 |



## CERTIFICATE OF SERVICE

I certify that on the 26th day of March, 1974, I mailed true and correct copies of the foregoing to Marx Leopold, Esquire and Barry Roth, Esquire, Counsel for Defendants, at their offices at Office of Legal Counsel, Department of Public Welfare, Health and Welfare Building, Harrisburg, Pa. 17120.

William Jameson

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

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[Caption Omitted]

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ARGUMENT ON PLAINTIFFS' MOTION FOR A CLASS ACTION DETERMINATION AND ON DEFENDANTS' MOTION TO DISMISS

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Philadelphia, Pa., April 16, 1974
(10:00 a.m.)

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Before:

Hon. John J. Gibbons, C. J.

Hon. Daniel H. Huyett, 3rd, J.

Hon. Raymond J. Broderick, J.

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(2) Present:

David Ferleger, Esq., Attorney for Plaintiffs, Mental Patient Civil Liberties Project, Philadelphia, Pa. 19107.

Barry Roth, Esq., Attorney for Defendants, Office of Legal Counsel, Department of Public Welfare, Harrisburg, Pa. 17120.



JUDGE GIBBONS: May we have the appearances?

MR. FERLEGER: My name is David Ferleger, counsel for the plaintiffs.

MR. ROTH: My name is Barry Roth, counsel for defendants.

JUDGE GIBBONS: We have this morning, in addition to the defendants' motion to dismiss, several items to which I'd like to have counsel address themselves. First, is the status of the plaintiff as a class representative, represented by a next friend, rather than a guardian ad litem. In that connection, we call your attention to the fact that in Dixon versus the Attorney General of Pennsylvania, Judge Biggs, in the opinion at 315 Federal Supplement, 653—actually, that's a per curiam, but it probably was Judge Biggs, suggests that where you seek class (3) action representation, it is inappropriate to have a person under a disability act in that capacity.

Tentatively, we think there is some merit to that position and we would like to have counsel the issue, where a guardian ad litem should be appointed and if so, who.

Secondly, the only defendants joined are state employees. We raise the question, whether or not, in the circumstances of this case, it would be appropriate to designate a class action defendant to represent the parents of class members. You will recall that Sierra Club versus Morton indicates that an organization which has members who are in the affected plaintiff class, can be a class action plaintiff.

We are suggesting at least the possibility that an organization which has members of an affected defendant

class, in this instance, parents of either retarded or mentally disturbed children, might be an appropriate class action defendant, because there is at least a possibility of conflict in the position taken by the institutional representatives and the position which should be taken on behalf of parents. We will of course hear you on the class action determination itself and finally, we will hear you on the motion to dismiss. (4) Keep in mind, that on everything that is before us, we have read your extensive briefs, and we only want to hear material that will enlighten us, beyond what you have in your briefs.

I suppose the starting place would be the State's motion to dismiss. Mr. Roth?

MR. ROTH: May it please the court, Your Honors, in connection with our motion to dismiss, I must state at the outset that the Commonwealth, in order to perhaps shorten the proceedings of this matter is basing almost entire reliance upon the regulations that were effectuated in order to continue implementing sections 402 and 403 of the Mental Health and Mental Retardation Act of 1966.

In short, Your Honors, we feel that those sections which permit a parent or person in standing in locus parentis to admit or commit his or her child, are constitutional and that they are a function of parental rights.

Now, since the inception of this lawsuit, the Commonwealth has attempted in its review of the law to determine whether or not any other cases have been brought regarding the same exact issue. At that time, we had discovered none. We did discover there (5) were serious questions as to affording juveniles the opportunity and right to be heard prior to commitment to an institution. The Commonwealth in attempting not to strip parents of



parental powers, effectuated regulations which would generally permit any juvenile, upon admission, who objects or subsequent thereto, to be afforded counsel and undergo what is known as a "406 Commitment Proceeding". It is a section 406 Commitment Proceeding under the Mental Health and Mental Retardation Act which is the section which refers to involuntary commitments of adults, meaning those who are aged 18 years of age or older.

Now, in connection with the implementation of these regulations, we consulted with opposing counsel for his comments. We had these published. Subsequently, we received criticisms and comments and suggestions and we, in September of 1973, implemented these regulations.

Now, since that time and in a conference with Judge Huyett several weeks ago, a question was raised as to how effective are the regulations. And for Your Honors, I have a copy of the number of cases since September, 1973, where a juvenile objected at or subsequent to admission and the procedure that occurred. If I may at this time, I would like to hand that to (6) Your Honors.

JUDGE GIBBONS: Thank you.

MR. ROTH: Now, our understanding of these, which were prepared by the Office of Mental Health and the Office of Mental Retardation, through telephone, contacted every private licensed facility, State mental facility, state school and hospital, was to determine exactly whether or not the regulations were being applied correctly or whether or not a juvenile who objected at or subsequent to was being given, if you will, additional safeguards, as we promulgated. It appears that in every one of these cases where juveniles objected at admission or subsequent thereto, a petition—

JUDGE BRODERICK: Mr. Roth, would you mind if I interrupted, I wanted to ask a question?

MR. ROTH: Yes, Your Honor.

JUDGE BRODERICK: I just wanted to ask you, would you tell us just what the procedure is under the regulations? I have read them over, and I just wanted a quick interpretation of what that procedure is.

MR. ROTH: Your Honors, there are specific sections in the regulations which we may classify as a referral in order to show how the juvenile arrives at the institution. In other words, he's been medically (7) examined, psychiatrically examined by a base service unit or by a pediatrician or psychiatrist. We are talking about two different classes here although affected by the same regulations and we are talking of a class of mentally retarded juveniles and those who are mentally disabled.

Now, basically what occurs, after the institution receives the application of that juvenile, the institution has an independent examination also conducted.

Now, when the juvenile is admitted to the institution, if the juvenile at the time of admission or subsequent thereto, anytime, meaning subsequent thereto, objects to his being admitted, he will be afforded counsel, he will be given the right to contact his parents or the person who petitioned on behalf of him to arrange his commitment to the institution and generally undergo a 406 proceeding. What basically happens, is the director of the institution will, if he feels that the juvenile is definitely in need of continued care and cannot be released to the petitioner, will then request that a 406 petition occur, which will basically put it before a judge in order for a hearing to be



held and to determine whether or not the person does need institutionalization.

It should be noted that we utilize two days in order to seek contacting the petitioner, as well (8) as perhaps the base service unit. We arrived at this 48-hour basis, because in Lessard versus Schmidt there was some dicta indicating that a person's due process rights should not be deprived for more than 48 hours. We even question Your Honors whether or not that should apply to juveniles because in this situation again, we are talking about the paramount rights of parents versus juveniles and that is basically what the procedure allows.

We also have a notice which is read to each juvenile, advising him or her of their rights upon admission to the institution and that juvenile has to be age 13 or older. For those that are aged 13 and younger, we provide no notice. If a juvenile is incapable of understanding what is being read to him or her, that, also is noted on the notice proper.

JUDGE HUYETT: Is there anything more done than noted on the notice that the juvenile cannot understand the notice?

MR. ROTH: No, Your Honor. If he objects, and that's the question again since our conference I tried to gather this information and one of the questions that I unfortunately did not ask when the people were making these calls was whether or not (9) those objections include people who did not have the mental capacity to exercise judgment. It is my understanding, that if you're 13 years of age or older and object and even do not have the requisite capacity to make that judgment, a 406 proceeding still will be afforded you. So, this classification,

perhaps may be broken down even more, based upon whether or not a juvenile has prerequisite mental ability to exercise judgment.

Now, the Commonwealth is aware that plaintiffs have raised a few cases in connection with procedural due process rights afforded juveniles, namely Heryford versus Park and Seville—I'm sorry, the last name escapes me. Both of those cases indicate that juveniles may be afforded due process rights.

Unlike the Pennsylvania regulations, those statutes in question do not have any other mechanism for affording a hearing upon detention, if so requested by the juvenile.

Pennsylvania feels that these additional regulations would promote and safeguard procedures for juveniles being committed to its institutions.

In connection with the entire scope of juvenile's rights, we also contend that if Your Honors (10) feel that this Statute, these sections of the Mental Health and Mental Retardation Act are unconstitutional, we seriously question whether or not deprivation of any juvenile for any amount of time, whether it is a greater or lesser amount of time, as against enunciated in Lessard versus Schmidt, would require a due process hearing prior to commitment and we refer as we referred last year this time when we were discussing this case, to particular instances where a parent may want to put his child into a general hospital for an appendectomy or anything of that sort. Certainly, we think that deprivation of liberty is deprivation whether it is one minute or 10 hours.

The question becomes, in our way of thinking is: How soon after that deprivation occurs do we resolve a



balancing interest between parents and child and state among those three parties by affording a hearing if the juvenile requests it? Now, there's been some factual data with regard to the number of juveniles who are admitted to the state schools and hospitals and state mental hospitals throughout the past year, and it's been indicated in one of the memorandums of law, as I recall, by plaintiffs, that the number is minimal and as a result, would require (11) very few hearings. Now, in just tabulating an approximate number of state schools and hospitals and state mental hospitals, it is my understanding that there were approximately 600 juveniles admitted in the state schools and hospitals and state mental hospitals for the year 1972.

Now, this precludes, of course, the private licensed facilities of which there are 164.

JUDGE GIBBONS: If I understand this paper that you handed up to us, since September of 1973, there have been 22 hearings held?

MR. ROTH: I'm sorry, Your Honor, I don't know where you are arriving at 22.

JUDGE GIBBONS: In every instance, but one that's listed here, there was a section 406 hearing.

JUDGE HUYETT: One hospital alone had 17.

JUDGE BRODERICK: There is one here that has six and another has a six and another 17.

JUDGE GIBBONS: I'm sorry. It is a good deal higher number.

MR. ROTH: Yes, Your Honor.

JUDGE BRODERICK: May I ask a question? I guess it was the plaintiff that submitted the article, the rights of a child to refuse treatment, which (12) apparently was the recommendation of the task force on mental health for children and youth. What is their status in regard to the Commonwealth?

MR. ROTH: Your Honor, I was just going to arrive at the various levels of where the legislature is, where the task force is. The task force is an advisory committee and the members of that committee are appointed by the Governor.

Now, that committee makes recommendations to the Department of Public Welfare. They are merely advisory. That same advisory committee agreed to the additional procedural safeguards which we adopted, and which is prefaced in the bulletin, also.

Now, again, you know, it puts me in a very difficult situation, because you have the task force on one hand saying "we think that a prior hearing should occur prior to commitment in every instance" and then, the department is saying "well, let's make certain that we do afford at least enough procedural safeguards that would satisfy due process". And, so, we implemented regulations to effect that. The legislature and I just want to, you know, bring everything to your attention, because perhaps, you know, it might be more helpful in arriving at a decision, (13) Senate Bill 1239 of which I have copies for your Honors, the legislature is attempting to utilize the same procedures now by having parents commit their children or persons standing in locus parentis being afforded the opportunity to admit or commit their children.

However, they want to reduce the age from 18 to 14. So, in all honesty, we are a bit scattered in the direction that's occurring, in that the senate at this time in Bill 1239, would like to have the juvenile apply for and receive treatment, if he is age 14 and older.



Under age 14, he would again be admitted or committed by his parent or the person standing in locus parentis.

JUDGE GIBBONS: Bill 1239 proposes that only the juvenile if he's over 14 can make the application?

MR. ROTH: It proposes that the juvenile shall be allowed to do so.

JUDGE GIBBONS: That's not—

MR. ROTH: I see your question.

JUDGE GIBBONS: Can the parent also do so? Do they propose that the parent also do so?

MR. ROTH: They say any person or the (14) juvenile.

JUDGE GIBBONS: That really isn't involved in this case, because as I understand Mr. Ferleger's position as distinct from the amicus brief that was filed by the San Francisco organization, the Youth Law Center, he is not objecting to the inability of a juvenile to voluntarily commit himself without his parent's consent. He's objecting to the ability of the parent to have him committed.

MR. ROTH: Yes, I understand that to be the issue also, Your Honor. I merely wanted to refer this other development as what is currently before the legislature for Your Honor's knowledge in terms of whatever you come out with in your order.

JUDGE BRODERICK: May I ask one other question? Who adopts the regulations? Is it just the department head?

MR. ROTH: Basically, Your Honors, what happens—

JUDGE BRODERICK: Would that be Mrs. Wohlgemuth?

MR. ROTH: She approves it and then they're approved by the attorney general, so in effect, it would be Mrs. Wohlgemuth's recommendation to the (15) attorney general for the adoption of the regulations?

MR. ROTH: Yes.

JUDGE GIBBONS: Do they have the force of law in this state under some administrative code?

MR. ROTH: They have the force of law under the administrative code and also under the Public Welfare code and I can give you the specific situations. I'm sorry, I do not have those citations before me.

JUDGE GIBBONS: What is your reaction to our concern about a possible representative of parent interests?

MR. ROTH: If I understand you correctly, when you were raising that, are you indicating at that time that in other words, a guardian ad litem should be appointed?

JUDGE GIBBONS: No, there are two questions. The guardian ad litem goes to the adequacy of the class representative, assuming we grant class action treatment. But that would leave a guardian ad litem as a class representative of the class consisting of actually or potentially involuntarily committed minors. It would leave the defendants, the state employees, whom you represent, but it would leave the representation of the parents who obviously have an interest in this statute in your hands.



Now, obviously, (16) the attorney general has some interest in advancing their point of view, also, I suppose, but is there a potential conflict between the interests of the institution and the interest of the parents? If so, should we consider whether or not somebody, let us say, the Pennsylvania Association of Retarded Children, which undoubtedly has members in the class of parents of the plaintiff class, should not be joined as a defendant, so that we get a different point of view?

MR. ROTH: I would think, Your Honor, in regard to that, that the state institution act is in a somewhat adversary position to the parent, and I say "adversary", in the respect that if the parent wishes to admit or commit his child and follows the procedures outlined, the institution still will have the ultimate say in whether or not that child is institutionalized based upon their independent determination—psychiatric determination.

So, if anything—

JUDGE GIBBONS: But the thing is, a parents' organization might be more interested in a longer waiting period than 48 hours and might have some cogent reasons for advancing that position. They might be interested in more freedom on the part of parents (17) to involuntarily commit than the institution is.

MR. ROTH: I appreciate that, and I agree with you, they very well may. I was just trying to look at it from the standpoint, when we are talking of juvenile rights and showing that we are taking this legal presumption and we are really making it somewhat of a rebuttive presumption that the child is not as parents have alleged, railroaded into institutions, that there is somewhat of a check by the institution proper, but I agree with Your

Honor, in connection with these regulations, parents groups did not submit any comments.

Most of the comments that were submitted were done by institutions, themselves, psychiatrists and I believe there was one comment by Park, as you referred to before, but the comments of parents' groups were not solicited, other than through the Pennsylvania Bulletin when we published the proposed regulations, but that may very well be, that a parents' group might have another view with regard to this. Our feeling is, and as you indicated before, not to go through our briefs, because of course, you have had them and read them, but our feeling is that parents do maintain certain responsibilities to their children and (18) among those responsibilities are the welfare and care of their children and the treatment of their children and included within that treatment is the medical and mental treatment and we feel very strongly that parents do have corresponding duties to make sure that their child is institutionalized, if necessary.

Now, with regard to the parents, we feel that the parents are the ones who first observed their child and were very concerned.

If this regulation is struck down, the parents and especially parents of poor socio-economic backgrounds will not utilize any type of procedure to get his or her child institutionalized. That as soon as you hear and from what I have heard in institutions, as soon as you hear the word "doctor" or "lawyer", poor people tend to preclude utilizing those systems, because based on their unfamiliarity with them, they're afraid and as a result the one that's being hurt the most is the one whose best interest we are trying to serve, the child and we think



there is a balancing interest here between the parents' and child' rights, and we hope we have established a fair balance by utilizing these additional safeguards.

Now, if those safeguards were found to (19) be acceptable, but perhaps the waiting period should be extended or something of that sort, of course, you know, we would do whatever the court ordered and we could always amend other regulations to reflect that, but with regard to the entire scope and the intent, we feel it would be absolutely anathema to parents and to the institution proper to now have to go through a procedure which basically can occur subsequent to the admission, if the juvenile objects.

JUDGE BRODERICK: Mr. Roth, let me ask you this: Have you considered what were the attorney general's or the department's objection to the recommendation for a precommitment hearing on the basis that's recommended here by the Task Force? I am sure you're familiar with their recommendation. In other words, what did the Commonwealth object to as far as that recommendation is concerned? Why wasn't it adopted, for instance?

MR. ROTH: Well, the recommendation came out after the advisory committee had already approved the regulations which were implemented.

JUDGE BRODERICK: Oh.

MR. ROTH: So, they were later and also—

JUDGE BRODERICK: The reason I ask that question, it is said in this article that was (20) submitted by the defendant, that the Task Force was asked by the Advisory Committee to make recommendations regarding ap-

propriate safeguards. It may have been afterwards, but it does not indicate that in the introduction.

MR. ROTH: I will be glad to elaborate. I approached the Task Force back in January of 1973, I guess it was and indicated the proposed regulations, and I told them at the time that what we were trying to do was afford juveniles additional procedures, safeguards, and I asked them for their comments. At that time, we did not have two days, we had ten days. At that time, we had several other provisions which, for example, with regard to the mentally retarded and the mentally disabled, since I am a layman when it comes to determining the routes that a mentally retarded child or a mentally disabled child should pursue, I had put in that it would be recognized or referred from a recognized authority and referring specifically to a medical authority. What they did at that point, was distinguish and they said, mentally retarded should seek this course prior to admission to an institution.

Mentally disabled, another course. Those were the types of discussions we had, Your Honor, and then, afterwards, in March, when we published (21) the proposed regulations, we received comments.

Again, I met with the advisory committee and subsequently, we again discussed the situation, it had not been brought to my attention that they objected to them. We even placed, within the regulations here that they had been discussed with the Advisory Committee and approved.

Now, with regard to the entire concept of their change, certainly, as an instrument in the Commonwealth, I am willing to make any changes that are necessary, but



I was directed then by my superior, Secretary Wohlgemuth to implement these regulations, and they were signed off by her and the attorney general.

JUDGE BRODERICK: Prior to receiving this recommendation?

MR. ROTH: Yes, but I am not exactly sure when that recommendation was dated, but I do know, Your Honor, that with regard to the specific regulations in question, they were discussed with the Advisory Committee and the Advisory Committee, for all purposes can advise us and say do this and we may just take that as it is, advice, and not do it, but at the time we talked about the prior hearings, we talked about prior hearings as well as subsequent hearings and how we could effectuate it and make these regulations (22) stand. The committee at that time was very concerned that parents still be able to voluntarily admit or commit their children, so as a result, we continued along the path which I previously suggested, of effectuating these additional regulations.

JUDGE GIBBONS: Well—

MR. ROTH: I'd be more than happy—I'm sorry, Your Honor.

JUDGE GIBBONS: There seems to me to be four problem areas remaining. One is the 48-hour problem. One is the problem of those over 13, but lacking mental ability to exercise judgment. Another is those under 13, who apparently do not even get notice and the fourth one is those over 13. Actually, the three categories of persons and then, with respect to everybody, this 48-hour issue.

With respect to those over 13, only the 48-hour issue remains, I would think.

MR. ROTH: Yes, Your Honor.

JUDGE GIBBONS: That is, if they have mental ability to exercise judgment. What about the others, the under 13's, particularly?

MR. ROTH: The way that was arrived at, Your Honor, the doctors and the Commissioner of Mental Health and Mental Retardation advised me at (23) the time that in their opinion, especially in their medical opinion, the Commissioner is a psychiatrist in mental health, that those aged 13 or younger really were incapable of exercising any type of judgment. I don't necessarily know that that cures it, but—

JUDGE GIBBONS: Don't we need evidence on that?

MR. ROTH: Yes, Your Honor, we can—

JUDGE GIBBONS: Don't you think we would have to hold a hearing and develop some evidence on that?

MR. ROTH: I would be very pleased to have an evidentiary hearing indicating, you know, what types of juveniles are brought into the institutions.

There were several misleading statements, for example, in the two thousand pages worth of interrogatories that we answered. There was a notation that in some instances, a juvenile was institutionalized because he was a runaway. Now, one of the things which has been very difficult, and I am not saying that the state system is not misused, where juveniles who should not be admitted were admitted, I am sure that does occur. However, I don't think it is as vast as it may appear in some of the state (24) facilities and the reason I feel that is because I have



been told that personnel people at the institutions were going through the voluminous charts and it is not unlikely for a patient whose been in a hospital for a year or two years to have a file cabinet of charts, and they literally went through the charts and wrote down what they first saw as the first note with regard to the admission of the juvenile.

So, if they saw something that said "runaway" or "schizophrenic" they may not have put down the entire thing, they may have put down "runaway", things of that sort.

It is very discouraging and, of course, I am apologetic, because it should have been put in a better framework. However, we were trying to gather information to give Your Honors a feel of exactly what is occurring and the number of juveniles that were admitted and the number of those that objected and what procedures are utilized.

There is no argument in this lawsuit that juveniles are being denied a right to treatment. In fact, plaintiffs' comment that they are in fact being granted their right to treatment.

I think an evidentiary hearing would be (25) extremely helpful in connection with showing what kind of procedure occurs, what kind of backup work, if you will, goes into a psychiatrists meeting with parents, with the child and then independent of the child, to determine if the procedures utilized are sound procedures. If they are not, okay, we will change them. But if they are sound procedures and affording a minimum due process for juveniles, then we feel the regulations should remain intact. Now, I am concerned in the sense that I would

like advice from Your Honors as to if we were to hold an evidentiary hearing, exactly whom you would prefer to have representing the institutions. Shall we ferret out individual institutions, shall we have somebody renowned in the field coming in? In other words, I would like to keep the scope of it as narrow as you would like to make the proceedings move as quickly as possible, also.

JUDGE GIBBONS: We could come back to that, but I think you can gather from the thrust of the discussion that we are pretty much committed already to having the case go forward as a class action?

MR. ROTH: Yes, I realize that.

JUDGE GIBBONS: What is your position with respect to the appointment of a guardian ad litem, rather than allowing it to proceed on the basis of (26) a next friend?

MR. ROTH: Your Honor, very honestly, I was reviewing and thinking about this, and it was almost as in my initial motion to dismiss, I had claimed Haverford State Hospital could not be sued because it was not a person within the meaning of Section 1983 of the Civil Rights Act. With regard to the technicality involved, I am really at the court's pleasure. I really do not object to the going through with Mr. Ferleger as a next friend. I certainly do not want to impede the progress of the lawsuit.

By the same manner, I certainly do not assert that we are wrong, but I certainly would like to get to the merits of this lawsuit.

JUDGE GIBBONS: I take it that you have no objection to having either a co-defendant or an amicus designated to represent parents' interests?



MR. ROTH: No, I would appreciate that, Your Honor.

JUDGE GIBBONS: We will hear from Mr. Ferleger now.

MR. ROTH: Thank you, Your Honor, Your Honors, may I ask one question, please?

JUDGE GIBBONS: Yes.

MR. ROTH: With regard to the class (27) action, will that be eventually divided into subclasses, since we are talking of both mentally disabled and mentally retarded, 18-year olds as well as three-year olds?

JUDGE GIBBONS: I think we should discuss subclasses. Before we leave today, we will take that up.

JUDGE BRODERICK: May I ask another question? I just wondered, Mr. Roth, if you had discussed the effect of the decree in the Park Case, as far as this problem is concerned with the mentally retarded, since my recollection is that in the Park Case, there were commitments made by the Commonwealth to provide for a—we will say a pre-commitment hearing, a pre-change hearing and it may well be that the decree in the Park Case could have taken care of at least some of the problems.

I do not say it takes care of all of them.

MR. ROTH: I haven't looked into that as affecting the case, Your Honor, but I shall do so.

JUDGE BRODERICK: One other thing, I think there were regulations that were promulgated in connection with the decree in the Park Case and those regulations, I thought, applied specifically to the (28) retarded

children, rather than those that had some mental disturbance. All right.

MR. ROTH: Thank you.

JUDGE GIBBONS: Mr. Ferleger?

MR. FERLEGER: Good morning, Your Honors.

JUDGE GIBBONS: Don't spend time on the motion to dismiss. I think you have got our drift that this is going to have to go to an evidentiary hearing.

MR. FERLEGER: I will try to get to the point that Your Honors have raised this morning. First, I'd like to say that from the plaintiffs' point of view, this is not a parental right's case, notwithstanding for the moment that courts used these sections that are challenged and welfare agencies and social workers. The law has come a long way since children's rights were always subordinate to parent's rights. We recognize that, but nevertheless isn't it at least an arguable position that parents have some interest in this matter?

Certainly they do and in cases in our society, where parent's interests and children's interests have conflicted in the area of child abuse, child neglect and dependency laws and even in certain school cases, the courts have been very careful to make sure that the due process and other rights (29) of children were protected and that in many cases, children were given the opportunity to have counsel and guardians ad litem for the purposes of protecting their rights.

In this situation, we have here, I'd like to address first very quickly the question of the per curiam opinion in the Dixon Case that Your Honor raised with regard to



whether or not guardian ad litem should be appointed. I am pleased that Mr. Roth is willing to have me prosecute the case as next friend.

At the same time, I would like to note that according to Rule 17(C) of the Federal Rules of Procedure, the court can appoint a guardian ad litem or allow the suit to be prosecuted by a next friend.

JUDGE GIBBONS: Does not 17(C) if you can proceed as a next friend, except in a representative capacity?

MR. FERLEGER: "If an infant or incompetent person does not have a duly appointed representative, he may sue by his next friend or by a guardian ad litem".

Pennsylvania law says that children can choose their next friend. Judge Biggs in the per curiam opinion did not discuss, to my recollection, the details that we have discussed in our brief of Pennsylvania law with regard to representation. I (30) would suggest that if the court wishes to solidify the situation and be sure of the court's position, that the court might consider transforming me from a next friend to a guardian ad litem in order for me to be under perhaps closer supervision of the court.

In another case, Judge Van Artsdalen, a case that I brought, during a hearing was faced with a situation where a minor was testifying, a minor ex-mental patient.

JUDGE GIBBONS: State defendants do not object to that procedure, and I think we would be more comfortable with it, because there is some question whether we can grant class action treatment, designating one or more of these minor plaintiffs as a class representative with a fiduciary obligation to absent class members. So,

would you prepare an appropriate order, designating yourself as guardian ad litem for one or more of the plaintiffs and, of course, submit it to Mr. Roth for approval, as to form, before you submit it to us?

MR. FERLEGER: Certainly, Your Honor. I will.

JUDGE GIBBONS: All right, now, that being behind us, let's get on to the subclass issues.

(31) MR. FERLEGER: With regard to the subclass issue, Your Honor, in considering both the mental health cases which we have cited which hold that due process adheres in mental health cases and the juvenile cases which have similar holdings for commitments to juvenile institutions, I am struck with regard to subclasses by the fact that there has never been any consideration of subclasses in those cases. With regard to adults as well as children, there are people who are committed to mental hospitals who are not competent, in a loose sense, to understand the proceedings.

I have represented some of them in commitment hearings. There are adults who do not understand the nature of the proceedings and who need counsel present in order to safeguard their rights.

There are juveniles, for example, in Heryford versus Parks, there was a nine-year old feeble-minded boy, Charles Parker who the court ruled needed a guardian ad litem to protect his interests. It seems to me from every juvenile from age one, to age 18, which is where the regulations now go, they need both counsel and a hearing and for younger and incompetent children, a guardian ad litem.

(32) JUDGE GIBBONS: Your point is that insofar as the complaint makes a due process attack on the



state regulations, all class members are in the same position?

MR. FERLEGER: That's correct, Your Honor. I, frankly, cannot see how subclasses can be workable, unless you first have hearings to determine whether or not the 12-and-a-half-year-old knows what he or she is doing or does not know what he or she is doing. I think you need counsel and a guardian ad litem in all cases, especially—

JUDGE GIBBONS: We will permit the action to go forward as a class action, designating a single class at this time, and I would have you prepare a form of order making such a designation, but providing in the order that it is without prejudice to possible designation of subclasses at a subsequent stage in the proceeding.

MR. FERLEGER: Certainly that's the way I understand the rules to provide and I will prepare that.

JUDGE GIBBONS: This is a class action under 23(B)(2), so there is no notice problem.

MR. FERLEGER: That is correct, Your Honor.

(33) JUDGE GIBBONS: Refer to that in the order, please.

MR. FERLEGER: Certainly.

JUDGE GIBBONS: Now, the description of the class will be persons under 18 years of age—

JUDGE HUYETT: 18 and under.

JUDGE GIBBONS: Yes.

MR. FERLEGER: I can read the way we defined it in the complaint. Paragraph 7, the class is defined as

all persons 18 years of age or under who have been or have been admitted or committed to state mental health facilities under the challenged provisions of the state statute.

JUDGE GIBBONS: That sounds all right.

MR. FERLEGER: I omitted the particular mention of Haverford State Hospital, since that's included.

JUDGE GIBBONS: While I think of it, we need an order dismissing Haverford State Hospital and submit such an order, please.

MR. FERLEGER: I can submit an order.

JUDGE GIBBONS: You will make an order, then?

MR. FERLEGER: Yes.

JUDGE HUYETT: Under rule 21, you can (34) do this only by court order, as I understand the rule.

MR. FERLEGER: I would like to address for a moment the question the court has raised with regard to the parents' representatives and then, I would like to talk briefly about the regulations and the plaintiffs' objections to the present regulations.

The major difficulty that I have with the need for a parent representative is that parents are not the only class which commit children under these provisions. There is a large number of children committed by social welfare agencies, by Catholic social services, by county departments of welfare, to mental hospitals. Courts, as well, use the mental health act to voluntarily commit children. I think it is probably the rural county courts that do not want to bother with the hearing, so the judge signs a child into a hospital as a person in locus parentis.



In addition, aunts and uncles and grandparents very often get involved with committing children. I see the possible interest of a group, such as P.A.R.C., in representing parents of retarded children, but I don't think they can be class representative for all the other people in locus parentis who commit children under the Act. It is my feeling that insofar as the state's (35) position has been, at least, up until today, that they are here to protect the parents' rights, as well as the institutions' rights, that I just do not see what additional facts or law the parents' organization could bring, even if they were to be considered an adequate representative.

In the mental health cases that I am familiar with and in the juvenile cases, I cannot recall any instance where parents of juveniles were called in to determine—help determine what due process meant for juveniles and in mental health cases, even in court commitment cases, there is always a petitioner, there is always somebody who wants a friend or relative committed and the courts, it is my feeling, have to determine what due process requires in a sense regardless of what the petitioner feels that it does.

JUDGE GIBBONS: But the difficulty with that, is that unlike the legislative process, where the competing interests are apt to be brought to the decision makers' attention, when you framed the lawsuit by designating a defendant, in designating a defendant, you have designated the source from which we are going to get the information and which we make what amounts to a legislative judgment.

MR. FERLEGER: I do not believe, Your (36) Honor, that a decision, with regard to what due process is re-

quired before deprivation of liberty is a legislative judgment. I believe that's a constitutional judgment.

JUDGE GIBBONS: You can call it a constitutional judgment or you can call it a decision of the lawsuit, but in fact, if we were to make a choice between a 48-hour waiting period and a 10-day waiting period, it would be a legislative judgment.

JUDGE BRODERICK: I would just like to add, Mr. Ferleger, your very argument that you have just made, that the parents and these welfare organizations and institutions have no interest and should not have an interest in this procedure is the very reason why I would want them to be represented, because, as a good advocate, you certainly are pushing for your point here, but I still feel that parents and these organizations should be represented somehow, whether it is as a party or amicus curiae in this matter, for the very reason that what you are attacking here, as I see it, you say it is not a parents' rights case, and you may be right on that statement, but it seems to me, you are saying that parents cannot waive the right to consent to the waiver of a due process hearing, which in effect is (37) what the act provides and what the regulations provide.

MR. FERLEGER: Right.

JUDGE BRODERICK: I do think we ought to get this input from that side, at least to determine whether or not such a decree which we make would infringe in any way on the rights of parents or the rights of these organizations.

MR. FERLEGER: It seems to me on the very question you feel you need that view on, that the Supreme



Court has already held in the juvenile cases that parents cannot waive their children's rights.

JUDGE GIBBONS: You may be right. That may be the way the lawsuit will come out, but nevertheless, there is at least another side to it.

MR. FERLEGER: I certainly would not stand in the way of the court getting the views of anyone that you feel is necessary. I am just not sure who it would be.

JUDGE GIBBONS: Assuming we want to proceed in that direction, do you have any suggestions?

MR. FERLEGER: Yes, in terms of—I don't know who can represent the county welfare departments, except perhaps the present defendants.

JUDGE GIBBONS: Well, the Attorney (38) General's office is here. I would think that any state agency is adequately represented.

MR. FERLEGER: With regard to the mentally retarded, it seems to me that the P.A.R.C. is the only representative I can think of.

JUDGE BRODERICK: Isn't there a similar organization to P.A.R.C. for those that are mentally disturbed?

MR. FERLEGER: Yes. I don't know if it is quite similar. There is an organization called Pennsylvania Mental Health, Incorporated, P.M.H. and Pennsylvania Mental Health has been involved both with the state in various reports and studies. They just had a commission do a study of the whole state mental health system, and I think they may have participated in lawsuits before. I am not certain, but I think the mentally ill, rather than the retarded also would need a representative.

JUDGE GIBBONS: Suppose that we were to designate such organizations as amicus, with the right to participate and examine and present testimony. We would not have to make them parties. Would either side have any objection to that procedure?

MR. FERLEGER: Not, if that's what the (39) court wishes, Your Honor.

JUDGE GIBBONS: My next question is: Can we impose the duty on counsel to approach two organizations that have been discussed or any others that occur to you, I do not want to turn this thing into an electrical antitrust case or something, and find out their willingness to participate as amicus, keeping in mind that they will not be parties.

MR. FERLEGER: I am sure Mr. Roth and I can approach them.

JUDGE GIBBONS: You also mentioned some representative of social agencies.

MR. FERLEGER: Catholic social services I know is one that participates as well as various county welfare departments. I am not certain and maybe we can find out, whether there is some association of welfare agencies. I would guess that there is.

JUDGE GIBBONS: Certainly, we would be more comfortable having such agencies participate, at least as amicus, because what we have in mind is that you have already achieved—I don't know whether the state would have moved in this direction anyway—but you have already achieved substantial progress with regulations and asking us to go further is asking a lot. (40) We want to be sure we are on sound ground from everyone's point of view.



MR. FERLEGER: I would like to address the regulations for just a moment, Your Honor. The 48 hour provision of the regulations is not what it seems. Within the 48 hours after an objection by a child over 13 years old, the mental hospital has to contact the applicant, the parents or the agency and then begin to get a 406 Hearing, a court commitment hearing. There is no provision in the regulations that the court hearing has to be held within 48 hours, within a week, within a month or within two months?

JUDGE GIBBONS: We realize that. The regulation is saying that the hearing had to be held within 48 hours would not work, knowing the way courts operate.

MR. FERLEGER: In the Lessard Case, the court held that after someone—in order to show somebody dangerous and mentally ill, you need a probable cause hearing within 48 hours and then a full due process hearing within 10 days to 14 days.

JUDGE GIBBONS: We realize that that problem remains, that there may be the need for a two stage hearing procedure.

(41) JUDGE BRODERICK: May I ask a question, Mr. Ferleger?

MR. FERLEGER: Certainly.

JUDGE BRODERICK: With regard to the recommendations of the Task Force that you submitted, would their recommendation, if it had been adopted or if it should be adopted in the future by the Commonwealth, would that give you the protection you think is necessary?

MR. FERLEGER: Yes, Your Honor, Those recommendations, which were by the Task Force on children and

youth to the Advisory Committee, I think there might have been some confusion before, the Advisory Committee on mental health of the Welfare Department decided to reject those recommendations in making their comments to the secretary, but those recommendations, the way I read them, support the plaintiffs and would provide for a pre-commitment hearing.

JUDGE BRODERICK: I think they do and the only thought that occurs to me is that there may well be that the attorney general would be happy to discuss those, to see whether or not they might be willing to adopt them at this stage.

(42) MR. FERLEGER: I would approve of that. I think that would dispose of this lawsuit.

JUDGE BRODERICK: That is what I was hoping that you would say in answer to that.

MR. FERLEGER: The regulations, by only providing for children over 13 to have this opportunity for some due process in my mind do not protect those who need the most protection.

The child over 13, who does not know what a court looks like or does not know what a lawyer looks like or is too incompetent. The child nine years old or five years old, who gets committed, are the ones who need the most protection. They are the ones who need a guardian ad litem and counsel the most.

JUDGE GIBBONS: What is your position about the 13-year-old classification per se? Aside from the fact and I realize that you want to make for those some automatic hearing requirements, but is that a reasonable age decision on the part of the—



MR. FERLEGER: You mean if the procedures and regulations are proper, is 13 years old a reasonable cut off?

JUDGE GIBBONS: The point at which the notice is given to the child and an opportunity given (43) to ask for a hearing, rather than making it automatic?

MR. FERLEGER: To be honest, Your Honor, I am not that certain, because I do not know many children between nine and 13, and I am not sure what their usual capacities are. The oldest child I know is about six. It seems to me that as the court held in Heryford versus Park, you need the full hearing for all ages. I was re-reading Heryford briefly—

JUDGE GIBBONS: Whether or not the child asks for it?

MR. FERLEGER: That's right. In juvenile court, I am not certain whether a juvenile can come into court, and waive, without counsel or a guardian ad litem and waive the right to a hearing before commitment to a training school or reform school.

JUDGE HUYETT: What would be accomplished at a hearing with a child of let us say five years of age?

MR. FERLEGER: Counsel for the child could cross-examine the doctors who are testifying in support of the commitment, could examine the parents and other witnesses, to determine the facts. I mean all these cases to me show extreme caution by courts when fact-finding results in commitment and if a parent comes in, as happened in Pennsylvania and says, "My (44) child sits in front of the television all day and does not do anything and does not have friends and this child is mentally ill, then I think

you need a court and counsel representing the child to show the other side of the story, because there always is one.

JUDGE GIBBONS: Why, a court, necessarily? You see, this is where I tend to part company with you. There are all sorts of administrative procedures that have withstood due process and challenge and while I realize that commitment to a confined place is a very fundamental change in your status, is it necessarily required judicial action, rather than only judicial review?

MR. FERLEGER: Well, I have never seen a case, Your Honor, in which deprivation of liberty in terms of institutional commitment has ever been subject simply to the approval of administrative agencies, rather than courts. In Pennsylvania, masters hold the hearings in some counties in mental health cases, masters who are appointed by the court and make their recommendations to the court. That, to me is still a judicial proceeding and not an administrative proceeding.

JUDGE HUYETT: Masters would be lawyers?

(45) JUDGE HUYETT: There are only so many judges and recently I held a violation of probation hearing that took seven days and these hearings could be rather lengthy and there are only so many judges.

MR. FERLEGER: It could be. When Dixon was decided and the court in the middle district ruled section 404 unconstitutional, the New York Times pointed out that 14,000 patients were in Pennsylvania hospitals unconstitutionally and all those 14,000 people had to be converted to either voluntary commitments or court commitments.

JUDGE BRODERICK: You are not suggesting that because the New York Times said 14,000 that that's the



correct number, because they did not indicate that in the Dixon opinion itself as to numbers.

MR. FERLEGER: The Dixon opinion just discussed the patients at Fairview and in three paragraphs ruled section 404 unconstitutional.

JUDGE BRODERICK: I think that is all they had in front of them in that particular case, but that's neither here nor there.

MR. FERLEGER: It seems to me there wouldn't be all that many hearings required and the hearings that are required are needed and the fact that (46) more judges might be needed is irrelevant.

JUDGE GIBBONS: We can't look at it that way. There is no point in our devising a remedy that will not work. I am much more interested in devising a remedy that will work. The State of Pennsylvania could frustrate any procedure we devise by adopting an assignment of judges to other work and having these things pile up. Now, I would like to hear, when we get to final hearing what's wrong with some sort of administrative hearing, perhaps before doctors, adversary in nature, with a provision for judicial review, if necessary.

It seems to me that that would be functionally and in some respects preferable, because it would be a hearing before an agency that has a greater expertise than the typical judge.

MR. FERLEGER: Your Honor, we cite in our brief a case called Anderson versus Solomon, I believe a three-judge court case in Maryland, challenging the commitment law.

After it was brought, the statute was changed, also similar to the regulations that we have here and the court in ruling on the new law said it continued to be unconstitutional, because a mandatory (47) judicial hearing was not required, because in that case, you only received a judicial hearing if you requested one.

JUDGE GIBBONS: Not required at any stage.

MR. FERLEGER: That is right.

JUDGE GIBBONS: That's a different thing. I am not suggesting that judicial review would be eliminated, because as I understand it, habeas corpus is always available. So there is always the possibility in Pennsylvania of judicial review of whatever is done, but your due process attack is on commitment without hearing first.

MR. FERLEGER: Yes.

JUDGE GIBBONS: What I am suggesting to you is that the due process point might well be eliminated by a provision for administrative level hearing in all cases.

MR. FERLEGER: I understand your position and maybe we can brief that point further at some later point.

JUDGE GIBBONS: It seems to me that that is a more practical road to go down.

MR. FERLEGER: Your Honor, I just want to conclude by noting some of the facts in the (48) Heryford versus Park Case. The statute involved provided for hearings. The statute involved provided things almost similar to the regulations here. They provided that if a parent, for example, wanted a child committed, the parent filed a petition with the D.A. The prosecuting attorney had to file medical histories of the patient—potential patient. The



court had to have a hearing in which the medical evidence was presented even to the court and the 10th circuit struck down that statute for the reason that the child did not have counsel appointed and did not have the right to confront the evidence before a judicial officer.

JUDGE BRODERICK: I can understand that.

JUDGE GIBBONS: That can be afforded in an administrative level.

MR. FERLEGER: It could be, Your Honor. I would very much appreciate the opportunity to address that point, because it sems to be an original one, because in no mental health case that I know of, has administrative bodies been granted the right to decide when people are deprived of their liberties.

It is not final. The possibility of judicial review would always have to remain.

MR. FERLEGER: In that case, Your Honor, (49) somebody would be deprived of the judicial review through a certain period of commitment until the review can be obtained.

JUDGE GIBBONS: Exactly. Well, I think at this point you know what's bothering us and you know what we want to hear at a final hearing.

Submit an order denying the motion—the motion to dismiss and how soon can you be ready for an evidentiary hearing?

MR. FERLEGER: I think it might be best for Mr. Roth and I to discuss what sorts of stipulations we could arrive at. We talked about that a little bit with Judge Huyett in chambers.

JUDGE HUYETT: Maybe we need some type of order relating to the hearing, so we can define the issues and who the witnesses might be and what their testimony would be, so that all of it is controlled and it does not take longer than it need take.

JUDGE BRODERICK: Yes.

JUDGE HUYETT: I could prepare a proposed order and submit it to the three of us for your review.

JUDGE GIBBONS: Yes. Take up the date of the hearing and the scope of the hearing with Judge Huyett who will enter a pretrial order.

(50) MR. FERLEGER: Your Honor, as I understand it at this point, I will prepare and submit to Mr. Roth orders with regard to the class, with regard to dismissing Haverford Hospital as a defendant, with regard to a guardian ad litem and denying the motion to dismiss?

JUDGE GIBBONS: And the amicus matter.

JUDGE BRODERICK: Recommendations as to—

MR. FERLEGER: Right.

JUDGE GIBBONS: What we should do on that, after counsel approach appropriate agencies, have the agencies prepare a petition for leave to participate as amicus with an order attached.

MR. FERLEGER: Right. Thank you.

JUDGE BRODERICK: All right.

JUDGE GIBBONS: Court is adjourned.

(Whereupon, at 11:25 a.m., court was adjourned.)



IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

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Civil Action No. 72-2272

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Kevin Bartley; Steve Gentile; Leslie Levine; Vicki Mathews; Mark Weand, minors, through their next friend, individually and on behalf of all others similarly situated,

Plaintiffs

v.

Haverford State Hospital; Jack B. Kremens, Hospital Director of Haverford State Hospital; Helene Wohlgemuth, Secretary of Public Welfare of the Commonwealth of Pennsylvania; William B. Beach, Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,

Defendants

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ORDER

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AND NOW, this 29th day of April, 1974, upon motions by the parties and argument thereon, and after consideration by this Court, it is hereby ORDERED that:

1. Haverford State Hospital be and hereby is dropped as a party defendant in this action. The com-

plaint heretofore filed shall stand amended by the elimination of Haverford State Hospital as a party defendant.

2. This action shall be maintained as a class action under Rule 23(b)(1) and (2) of the Federal Rules of Civil Procedure on behalf of the class comprised of all persons eighteen years of age or younger who have been, are or may be admitted or committed to mental health facilities in Pennsylvania pursuant to the challenged provisions of the state mental health law (i.e., 50 P.S. §§4402 and 4403). This definition of the class is without prejudice to the possibility that it may be amended or altered before the decision on the merits herein.

3. Pursuant to Rule 17(c) of the Federal Rules of Civil Procedure, David Ferleger, Esquire, Counsel for the Plaintiffs, is hereby appointed guardian ad litem for the plaintiffs and their class and he shall appear for them in this action and maintain it in their behalf.

4. The Defendants' motion to dismiss this action be and hereby is denied.

By the Court,
(s) Daniel H. Huyett
Daniel H. Huyett, 3d, *J.*



IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

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Civil Action No. 72-2272

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[Title omitted in printing.]

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ANSWER

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*First Defense*

*Preliminary Statement*

Plaintiffs in this Complaint attack the constitutionality of Sections 402 and 403 of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (50 P.S. 402, 403) which permits the voluntary commitment of persons 18 years of age or under by parents or persons standing in loco parentis. Defendants contend that these portions of the Act as well as regulations adopted in September, 1973, maintain the constitutionality of the attacked regulations and furthermore do not conflict with the Fourteenth Amendment to the United States Constitution.

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*Second Defense*

Defendants admit the allegations contained in Paragraphs 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21, 24, 26, 29, 33, 41, 38, 39, and 40; admit in part

allegation 22 that Plaintiff Bartley who was discharged on April 1, 1973, did not wish to enter the hospital nor remain and that Plaintiff Bartley was critical of hospital procedures and deny that any hospital procedures are arbitrary or inconsistent with beneficial treatment; admit in part allegation 23 that Defendants knew Plaintiff Bartley planned to go to school and learn a useable trade upon release because Defendants made arrangements for said school and deny that "nothing worthwhile is occurring to him inside the hospital" when in fact Plaintiff Bartley was receiving specialized treatment; admit in part allegation 28 that Plaintiff Levine's parents are divorced, that her father is remarried and living in Florida, that she would like to live with her father, and deny that she was solely committed to the hospital because she does not get along with her mother and sister when in fact she has threatened their lives several times and suffers from a personality disorder; admit in part allegation 32 that Vicki Mathew's parents on November 7, 1972 applied for and received Plaintiff Mathew's discharge from the hospital, that Defendants are without knowledge or information sufficient to form a belief as to the truth of the allegations concerning Plaintiff's parents' financial means; admit in part in allegation 34 that Plaintiff Weand did not wish to become a mental patient and has informed Defendants' agents and employes of his desires to leave which occurred on December 1, 1972, that Defendants deny that Plaintiff Weand was admitted because of excess use of drugs when in fact that is part of his problem which is a psychiatric maladjustment; admit in part in allegation 35 that Plaintiff Weand has not been involved with any therapeutic drug program because his condition warrants other treatment programs in which he has participated; admit in part



in allegation 43 that a person over 18 years of age who does not wish to enter a facility may be placed there involuntarily upon Order of the court pursuant to a petition, notice and hearing mandated by Section 406 of the Act, that Defendants deny that persons under 18 years of age who do not wish to enter a facility may be placed there when in fact adopted regulations of September, 1973 reveal that a juvenile who objects will be afforded counsel and ultimately a 406 hearing; and deny each and every other allegation contained in the Complaint.

Respectfully submitted,
BARRY A. ROTH
MARX S. LEOPOLD
*Assistant Attorneys General*
ISRAEL PACKEL
*Attorney General*
Counsel for Defendants

Dated: June 3, 1974

[Certificate of Service omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

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C.A. No. 72-2272

---

KEVIN BARTLEY, et al., individually and on behalf of all others similarly situated, by and through their guardian ad litem, David Ferleger,

Plaintiffs

v.

HAVERFORD STATE HOSPITAL, et al.,

Defendants

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FINAL PRE-HEARING ORDER

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In accordance with the Court's Order of April 19, 1974, as amended, Plaintiffs and Defendants submit this Final Pre-Hearing Order.

## A. STIPULATION OF UNCONTESTED FACTS

1. The Plaintiffs, individually and on behalf of all others similarly situated, seek declaratory and injunctive relief alleging that certain parts of the Pennsylvania Mental Health and Mental Retardation Act of 1966 which permit the commitment of persons eighteen years of age and under to mental health facilities on a different basis than other persons and without notice, hearing, right to counsel and other procedural safeguards conflict with the Due



Process and Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution.

2. Jurisdiction is properly conferred upon and assumed by the court. This is a proper case for determination by a three-judge court pursuant to 28 U.S.C. §§2281 and 2284.

3. This action shall be maintained as a class action under Rule 23(b)(1) and (2) of the Federal Rules of Civil Procedure on behalf of the class comprised of all persons eighteen years of age or younger who have been, are or may be admitted or committed to mental health facilities in Pennsylvania pursuant to the challenged provisions of the state mental health law (i.e., 50 P.S. §§4402 and 4403). This definition of the class is without prejudice to the possibility that it may be amended or altered before the decision on the merits herein.

4. Pursuant to Rule 17(c) of the Federal Rules of Civil Procedure, David Ferleger, Esquire, Counsel for the Plaintiffs, was and is appointed guardian ad litem for plaintiffs and their class and he appears for them in this action and maintains it in their behalf.

5. Defendant Jack B. Kremens, Hospital Director of Haverford State Hospital, is sued as representative of the directors of all mental health facilities in Pennsylvania, all of which are under the authority and supervision and regulation of Defendants Wohlgemuth and the Deputy Secretary for Mental Health and Mental Retardation.

6. The questions of law and fact involved are:

a. Are the representative parties, and their class, admitted or committed to Haverford State Hos-

pital and other mental health facilities pursuant to the challenged statutory provisions?

b. Are the representative parties, and members of the class, admitted or committed involuntarily?

c. Do Defendants operate, execute and enforce the challenged statutes?

d. Are the challenged statutes contrary to the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution?

7. Plaintiff Kevin Bartley is a citizen of Pennsylvania, age 16 at the filing of this action, having been born November 4, 1956.

8. Plaintiff Steve Gentile is a citizen of Pennsylvania, age 18 at the filing of this action, having been born March 20, 1954.

9. Plaintiff Leslie Levine is a citizen of Pennsylvania, age 15 at the filing of this action, having been born October 8, 1957.

10. Plaintiff Vicki Mathews is a citizen of Pennsylvania, age 15 at the filing of this action, having been born September 10, 1957.

11. Plaintiff Mark Weand is a citizen of Pennsylvania, age 15 at the filing of this action, having been born June 13, 1957.

12. Haverford State Hospital is a mental health "facility" under Section 102 of the Pennsylvania Mental Health and Mental Retardation Act of 1966. (Hereafter, the "Act"). It receives admissions and commitments of



persons, including Plaintiffs and their class, under said Act.

13. Defendant Jack B. Kremens is Hospital Director of Haverford State Hospital and is charged with supervision and administration of the facility (§§102 and 103 of the Act). It is to Kremens or his delegates that applications for admission, commitment and release must be made. (§§402(b), 403(b) and 403(c) of the Act).

14. Defendant Helene Wohlgemuth is the Secretary of Public Welfare of the Commonwealth of Pennsylvania which department has the power and duty to enforce the Act and to make all regulations necessary and appropriate to the proper accomplishment of the Act and to operate and assign functions to all state facilities. (§§201(2) and 202(a) of the Act).

15. The Defendant Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania has general authority to supervise and regulate mental health facilities within Pennsylvania.

16. Plaintiff Kevin Bartley was committed to Haverford State Hospital on November 30, 1971 under §403(a)(2) of the Act.

17. He was committed by his mother although he did not wish to enter the hospital.

18. Kevin Bartley was, and still is critical of the hospital and believes that some of the hospital's regulations are arbitrary, that the staff played favorites with patients, that unnecessary punishments were imposed for minor rule infractions, and that patients were transferred to locked wards as punishment for mere allegations of wrong-

doing, without hearing or proof. Defendants admit that Bartley was critical as above but deny the validity of his beliefs.

19. Plaintiff Steve Gentile was committed to Haverford State Hospital, allegedly involuntarily, on August 24, 1971, by his father under Section 403 (a) (2) of the Act.

20. Plaintiff Leslie Levine's mother committed her, allegedly involuntarily, to Haverford State Hospital on October 11, 1972, under Section 403 (a) (2) of the Act.

21. Levine's parents are divorced; her father is remarried and living in Florida; she would have (at the time of her commitment and the time this action was filed) liked to have been with her father because she gets along well with him. Every time she visits with her father, her behavior is excellent. Levine's difficulties in relating to her mother resulted in her commitment. Hospital records indicate Levine threatened the lives of her mother and sister and that she has a "personality disorder."

22. Plaintiff Vicki Mathews was committed to Haverford State Hospital, allegedly involuntarily, on August 9, 1972 by her parents under Section 403 (a) (2) of the Act.

23 Plaintiff Mark Weand was admitted to Haverford State Hospital, allegedly involuntarily, on June 23, 1972 by his mother under Section 402 (a) (2) of the Act.

24. Weand did not wish to become a mental patient and has informed Defendants' agents and employees of his desires to leave which occurred on December 1, 1972.

25. Section 402 of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (50 P.S. §4402) provides as follows: (Those parts which are challenged by



Plaintiffs as unconstitutional are emphasized by underlining [italics])

> Section 402. Voluntary Admission; Application, Examination and Acceptance; Duration of Admission.
>
> (a) Application for voluntary admission to a facility for examination, treatment and care may be made by:
>
> (1) Any person *over eighteen years of age.*
>
> (2) *A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.*
>
> (b) When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he may be admitted.
>
> (c) *Except where application has been made under the provisions of Section 402(a)(2) and the person admitted is still eighteen years of age or younger,* any person voluntarily admitted shall be free to withdraw at any time. *Where application has been made under the provisions of Section 402(a)(2), only the applicant or his successor shall be free to withdraw the admitted person so long as the admitted person is eighteen years of age or younger.*
>
> (d) omitted here.

26. Section 403 of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (50 P.S. §4403) provides as follows: (Those parts which are challenged by

Plaintiffs as unconstitutional are emphasized by underlinings [italics])

> Section 403. Voluntary Commitment; Application, Examination and Acceptance; Duration of Commitment.
>
> (a) Application for voluntary commitment to a facility for examination, treatment and care may be made by:
>
> (1) Any person *over eighteen years of age.*
>
> (2) *A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.*
>
> (b) The application shall be in writing, signed by the applicant in the presence of at least one witness. When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he shall be committed for a period not to exceed thirty days. Successive applications for continued voluntary commitment may be made for successive periods not to exceed thirty days each, so long as care or observation is necessary.
>
> (c) No person voluntarily committed shall be detained for more than ten days after he has given written notice to the director of his intention or desire to leave the facility, *or after the applicant or his successor has given written notice of intention or desire to remove the detained person.*
>
> (d) omitted here.



27. The only other provisions for civil commitment to a mental health facility provided by Pennsylvania law are:

> a. Section 404 of the Mental Health and Mental Retardation Act of 1966, 50 P.S. §4404, which permitted commitment of persons upon application of third parties (including parents, guardians, individuals standing in loco parentis, etc.) upon application with certificates of two physicians. Because this section was in violation of the Due Process Clause of the Fourteenth Amendment to the United States Constitution, this section has been declared unconstitutional. *Dixon v. Attorney General of the Commonwealth of Pennsylvania*, 325 F. Supp. 966 (M.D. Pa. 1971).
>
> b. Section 405 of the Mental Health and Mental Retardation Act of 1966, 50 P.S. §4405, permits involuntary detention of persons, regardless of age, under emergency conditions for no longer than ten days.
>
> c. Section 406 of the Mental Health and Mental Retardation Act of 1966, 50 P.S. §4406, permits involuntary commitment of persons, regardless of age, upon petition to the state court of common pleas, and after hearing and examination. The respondent to such petition has the right to notice of hearing, the right to counsel and the opportunity and right to present testimony and evidence in his or her behalf and to confront his or her accusers. The court may order outpatient or partial hospitalization instead of in-hospital commitment.

28. Voluntary patients over eighteen years of age enter facilities under the Act on their own volition and un-

der Section 402 or 403 and may leave and discharge themselves either at any time (Section 402) or upon proper written notice (Section 403). Plaintiffs and their class are denied such entrances and separation from the facility by the challenged portions of these sections of the Act.

29. A person over eighteen years of age who does not wish to enter a facility may be placed there involuntarily only upon the order of a court pursuant to the procedures, including a petition, notice, and hearing, mandated by Section 406 of the Act.

30. The county in which Polk State School and Hospital is located would have had only 33 additional hearings in 1972 for the juveniles who were instead admitted "voluntarily" by a parent or guardian under the challenged portions of the Act. Similarly, Whitehaven State School and Hospital patients would have required only 87 hearings.

31. The tables attached to this Order and numbered 1, 1a, 2, 2a, 3, 3a, 4 and 4a are true and correct statistical summaries of data submitted by Defendants herein, for the purposes of this action, they are accepted as correct. These tables do not reflect all the data given in response to the interrogatories and questionaire.

32. At the June 15, 1973 meeting of the Department of Public Welfare Advisory Committee for Mental Health and Mental Retardation, the committee requested that the Governor's Task Force on Mental Health of Children and Youth consider the rights of children to refuse treatment.

33. The Task Force's report, dated August 6, 1973, of the meeting of July 18, 1973, stated:



It was agreed that any child has a right to know why he was being institutionalized, that he should be given all of the relevant information regarding such a process, that he had a right to participate in the decision making and that he had a right to have somebody speak up for him. When the child's desires and interests conflict with those of the parents, it appeared highly appropriate that the child should be represented by counsel, rather than his parents. . . . Essentially there was agreement that the child's best interests would be served by holding a *hearing prior* to any commitment to an institution, rather than (as has been suggested by the Department of Public Welfare) a review of the circumstances after institutionalization. The principal reasons were:

(1) The Task Force felt that commitment without a hearing and without the safeguards of due process, representation of counsel and fair notice represented an unacceptable deprivation of liberty.

Young people with emotional problems should have the same rights under the law as delinquents. In those cases where juveniles are accused of delinquent conduct which would constitute a crime if committed by an adult, the court's have rules for procedural guarantees derived from criminal law. These may become the rule in a larger variety of cases having to do with "truancy" or "incorrigibility".

(2) The Task Force noted that the reasons for parents seeking institutionalization in a mental health facility for young people are often similar to or the same as reasons why children are brought up on delinquency charges, i.e., young persons may be refusing

parental authority, involved with drugs, not attending school, etc. The path chosen (mental health or delinquency) is often more a matter of the advice given to parents by social agencies, rather than a significant decision about delinquency or non-delinquency of the youth.

Under this direction juveniles would have such procedural guarantees as written notice of the charges in advance with ample time to respond, right to representation by counsel, privilege against self-incrimination, availability of witnesses for confrontation and cross-examination, and the evidence must prove the charge beyond a reasonable doubt.

(3) Disagreements exist among psychiatrists regarding diagnosis and the need for institutionalization. Research has indicated that when adults request subsequent review (even though already institutionalized) that approximately half are discharged. The implication is that persons may be committed when the justification does not exist "beyond the reasonable doubt." A prior hearing at least forestalls the unjustified deprivation of liberty.

(4) When the review process is followed, i.e., after institutionalization, it is recognized that the patient is at a disadvantage:

(a) He may have been subjected to a variety of institutional pressures, to medication, and to treatment which reduces temporarily his capacity to make the best presentation.

(b) The patient can not "shop around" to find a variety of advice and counsel from sources of his own choosing.



(c) A person in an institution, particularly a child or young person, away from his familiar and protective environment for a period of time may become somewhat disoriented and less judgmental.

(5) A young person ought to have the right of the *least drastic treatment alternative*. Before commitment to an institution is decided upon it should be clear that all other alternatives have been explored: outpatient treatment, partial hospitalization, placement in a foster home or some alternative environment.

(6) It is recognized that problem behavior on the part of a young person is often linked to family dynamics. Commitment tends to place the burden for the disturbed behavior on the young person. When a young person is institutionalized, there is rarely an orientation on the part of the hospital to require parental participation in the treatment process. In contrast, outpatient treatment often may require parental involvement.

The Task Force recognized that commitment does not necessarily mean that treatment will take place. In keeping with previous principles of the Task Force the position was taken that commitment should not take place unless there was a guarantee of appropriate treatment.

Recognizing the slow process of the courts, in recommending the use of a prior hearing, it was discussed further that consideration be given to a quasi-legal structure with special expertise to make these decisions. Analogous structures are the Civil Service Commission and the Human Rights Commission.

In summary, it was the essential position of the Task Force that in order to properly safeguard the rights of youth, when there is a question of the need for institutionalization, a prior hearing should be held to adjudicate the matter, with appropriate Due Process safeguards, preferably before a specially constituted quasi-legal body rather than the existing court structure.

## B. AGREED STATEMENT OF CONTESTED ISSUES OF FACT AND OTHER CONTESTED MATTERS

### 1. *Witnesses*

Defendants propose, in addition to those persons named in their earlier submission and listed below, to call as expert witnesses Dr. Derek Miller of the University of Michigan and Dr. James Masterson of the Cornell Hospital in New York.

Plaintiffs' position is that unless the Defendants prove that these persons were unavailable since the Court's Order of April 19, 1974, Plaintiffs object to their naming further witnesses.

Defendants' position is that, in their earlier submission, they stated that they were "attempting to secure other expert witnesses who have been up to this time, unavailable." Thus, they wish to have these two experts testify.

### 2. *Need for Hearing*

Plaintiffs' position is that there may be factual differences among expert witnesses regarding whether certain legal procedures may or may not be medically therapeutic for juveniles and whether and at what age juveniles may psychiatrically be thought fit to make application for treatment. It is the position of the Plaintiffs that these factual differences are irrelevant and not essential to the Court's determination of the legal and Constitutional questions posed by this action. A memorandum to that effect has been filed.



Defendants object to this in that expert testimony would reveal that there are contested issues of fact which are critical to the legal issues posed by this lawsuit.

### 3. *Discharge and Readmission Data*

Defendants propose as facts to be agreed upon the discharge date of each named plaintiff and the readmission date of any of the named plaintiffs as well as the petitioner, if any, and the precipitating behavior causing readmission. This information will be obtained from their medical charts.

Plaintiffs object as this is a class action; the discharge dates and readmission data for the named plaintiffs are irrelevant and not essential to determining the legal issues herein. Also, Plaintiffs object that these proposed facts have not themselves been submitted to the Court or to Plaintiffs.

### 4. *Monetary Liability*

Defendants submit that there is no monetary liability of any Defendants herein. See *Edelman v. Jordan,* U.S. (March 25, 1974).

Plaintiffs object on the grounds that *Edelman v. Jordan* does not eliminate all "monetary liability" by Defendants. That case dealt with equitable restitution of retroactive welfare benefits. Plaintiffs herein, however, do not now seek damages but will, at the appropriate time, seek attorney's fees and guardian compensation.

5. *Data in Interrogatory and Questionaire Replies*

Typed below are a number of paragraphs containing facts and data from the responses to interrogatories and questionaires submitted by Defendants. The language within each paragraph has been agreed to by the parties. There is disagreement on whether these paragraphs alone are sufficient or otherwise admissible. The positions of the parties are given below, followed by the paragraphs in question.

*Defendants' Position*

Defendants object on the grounds that they are an analysis by the Plaintiffs' attorney of the data collected by Defendants. As such, the Best Evidence Rule precludes such an analysis when the data itself is readily available to the court. Furthermore, since this court, in the instant case, is the trier of facts, only Your Honors are entitled to analyze the data and draw conclusions. We respectfully disagree with Mr. Ferleger's analysis.

Defendants further object to Plaintiffs' use of the analysis without the complete medical record of each patient before the Court. For the sake of administrative ease it is most common for these state facilities and private facilities which responded to Defendants' questionaire to record only the overt act precipitating the hospitalization of the patient without any further explanations. However, in the overwhelming majority of cases involved, the patient is suffering from some further mental infirmity such as mental retardation, which will become quite apparent to the court upon reviewing the complete medical chart of the patient, which we are willing to provide for this Honorable Court.



Defendants object to paragraph 1 below on the grounds that it is misleading to the court. Defendants agree that the records of the patients state these grounds for admission. However, an examination of the total record of each patient would in most instances reveal a further infirmity requiring hospitalization. Furthermore, all patients admitted to Pennhurst, Polk, and Western State Schools and Hospitals are also suffering from mental retardation. Moreover, all those listed from the private facilities mentioned in paragraph 1 have not objected to their hospitalization.

*Plaintiffs' Position*

Plaintiffs' position is that the paragraphs below contain portions of the responses to interrogatories filed and sworn to by Defendants. These give the Court a fuller context in which to view the grave issues presented in this action.

Plaintiffs have conducted an analysis of the voluminous data presented; Defendants have not. Plaintiffs have no objection, of course, to the Court's accepting as part of the record the full responses to the interrogatories and questionaires. It is for the convenience of the Court and the parties that these paragraphs are submitted for stipulation.

However, the present suggestion of Defendants that "the complete medical record" of hundreds or thousands of patients be dragged into court is ludicrous and untenable. We suggest the Court rely on the data which the Defendants were ordered to produce and which they agreed to produce.

*The very reason why the short explanations in the interrogatory replies are the matters essential to the Court*

*is given in the Defendants' own words*: THE REPLIES: "record only the overt act precipitating the hospitalization of the patient . . . ." The point of this action is that the "overt act" is a factual question which must be decided at a judicial hearing rather than decided by parents or agencies with often adverse interests or by medical personnel. In this light, the medical record amassed *after* admission is irrelevant.

Of course, many institutionalized persons have emotional problems or are retarded—this is also true for non-institutionalized persons. The issue before the Court, is the process for initiating institutionalization procedures and the crucial aspect is the factual situation which sparked the process and the procedures which flow therefrom.

Defendants state they "agree that the records state these grounds for admission." There is no reason to bar from the record these matters.

*Defendants' Position on Private Facilities Mentioned*

Defendants admit to paragraphs 5, 6, 7, 8 below. However, the state only licenses private facilities and does not supervise these facilities in the same way that they supervise the state mental hospitals and state schools and hospitals. Consequently, the state cannot be held liable should a private facility [be] in violation of the Mental Health and Mental Retardation Act of 1966. The injured party may bring a lawsuit against any such private facility.

*Plaintiffs' Position on Private Facilities Mentioned*

Regarding so-called private facilities, Defendants attempt to claim that they are somehow not involved and do not supervise them. This is absolutely incorrect.



The Defendants have the power to regulate all facilities, 50 P.S. §4102, and have exercised that power by promulgating *regulations for the private licensed facilities* which require:

> Admission and commitment of patients shall be in accordance with the Mental Health and Mental Retardation Act of 1966 and shall be accomplished by the use of forms developed by the Department pursuant to that Act.
>
> DPW Regulations Title 9100.

*Defendants' Position on Paragraph 8*

Defendants object to paragraph 8 below on the grounds that it is irrelevant to the issue at hand. This paragraph does not relate to the constitutionality of the statutes involved, but rather, discussed alleged violations of the statute by private facilities which are not under the state's direct control.

*Plaintiffs' Position on Paragraph 8*

This paragraph demonstrates how the rights of the class here are violated by facilities which, while subject to the mental health act, determine to ignore the law. Defendants are responsible for the licensing and supervision of these facilities yet do nothing to stop their unconstitutional behavior in admitting and committing juveniles without a hearing and without even following the procedures supported by defendants.

1. Children have been institutionalized in Pennsylvania mental health facilities for the following reasons as noted by the institution. The number following the name of the institution is the facility's patient number.

Runaway, incorrigible (Pennhurst #402)

Violent episodes (Polk #13,173)

Hostile, attacked children, attempted to set home on fire (Polk #13,077)

Robbed gas station (Mental Health Center of Carbon, Monroe, Pike Counties #M-0-0543)

Stole truck, car (Mental Health Center of Carbon, Monroe, Pike Counties #M-0-1210)

Member of gang which participated in robbery (Thomas Jefferson University Hospital #360233)

Stealing (Northwestern Mental Health Center #628)

Involved with altercation with ten year old girl whom he chased and struck (Allentown State Hospital #25380)

Firesetting (Northwestern Mental Health Center #620)

Delinquent behavior (Northwestern Mental Health Center #637)

Firesetting (Northwestern Mental Health Center #61)

Arson (Fairmount Farms #16187)

Firesetting, stealing (Western #281)

Runaway (Fairmount Farms #16187)

Runaway, truancy, delinquent behavior (Western #288)

The courts have committed juveniles to these same institutions for similar reasons including the following:

Aggressive behavior toward family. Refusal to attend school. Excessive demands of attention at home. (Western #285)



2. Mental health facilities sometimes cooperate with parents and relatives in doing what Judge (now Chief Justice) Burger, in a dissenting opinion, calls "farming out their kindred into mental institutions for motives not always worthy." *Kent v. United States,* 401 F.2d 408, 416, footnote 4 (D.C. Cir. 1968).

3. Children have wound up at institutions for the following reasons, in addition to their being mentally retarded:

Interim placement while family was on vacation (Polk #13,212)

A mother placed her child at Western because "father out of household in the military." (Western #144)

Hyperactivity interfered with the routine of household and disturbed family members. (Western #15)

A newly widowed father was able to place a youngster at Western because he was allegedly "unable to care for child." (Western #67)

Western accepted another child from a mother because of "desertion of father". (Western #131)

In another case, a mother and a father who themselves had emotional difficulties institutionalized their child because they held the "problems of the child . . . responsible for their emotional adjustment." (Polk #12,-82)

One institution accepted a juvenile because "difficult to care for Loretta and her presence confines the parents in the home." (Western #73)

A boy named Joseph left "no free time for mother . . ." (Western #13)

Family problems (Philhaven #5647)

Family conflicts (Institute of Pennsylvania Hospital #94-94-33)

Family problems, needed separation from the family (Western State, no number given)

Unmanageable at home, attitude of bold indifference, resents all discipline, compulsive eating (Allentown State Hospital #25741)

Problems with family (Philhaven Hospital #5692)

Began to have trouble handling his anger and hurt feelings towards his parents. Took these feelings to school with him. (Allentown State Hospital #25520)

Runaway, conflict with parents (Institute of Pennsylvania Hospital #94-93-74)

Physical burden on mother who has three additional children. (Western #36)

One of three mentally retarded in the family. Coping with this problem is simply too much for the family. (Polk #13,103)

Because argumentative and wanted to stay out of school. Patient's mother overdosed and was hospitalized. Patient then had to be hospitalized. (Warren State Hospital, no number given)

Neglect, Social Deprivation (Stillmeadow Home for Exceptional Children #1138)

Neglect, unstable home environment (Stillmeadow Home for Exceptional Children #1138)

Mother has tuberculosis (Western #129)

Emotional instability of mother (Western #127)



Hospitalization of mother is apparent reason for admission (Polk #11,985)

No serious behavior problem; admitted due to parents' inability to provide a satisfactory home environment (Laurelton #42)

Quite active and destructive. Illegitimate (Western #286)

Sometimes hyperactive. Illegitimate (Western #288)

Illegitimate. Inadequate mother (Western #227)

4. Polk accepted a young boy because "He has no playmates, planned activities, exercise. Presently he does nothing except sit in school and in front of the T.V. at home." (#12836)

5. Three children were committed to mental hospitals because of physical ailments. At Saint Francis' Hospital one child was committed for ulcerated colitis (#13-58-69); another for psychosomatic complaint (#11-81-06); a third was put in the Institute of the Pennsylvania Hospital for weight loss (#94-88-05).

6. There are five children in Saint Francis' Hospital for not going to school. This list is as follows:

school phobic (#12-87-29)
school phobic (#12-80-40)
school phobic (#11-17168)
non-school attendance (#14-18-89)
non-school attendance (#14-57-10)

7. A partial list of juveniles committed for drug related activities is as follows:

Mental Health Center of Carbon, Monroe and Pike Counties:

Overdose (#M-0-1174)
Overdose (#M-0-1165)
Drugs (#Z-0-1004)

McKeesport Hospital:

Medical overdosage (#S.K.)
Medical overdosage (#R.M.)
Medical overdosage (#R.W.)
Medical overdosage (#R.K.)
Medical overdosage (#T.G.)
Medical overdosage (S.C.)
Medical overdosage (T.S.)

Fairmount Farm:

Drugs (#16155)
Drugs (#16147)
Drugs (#16027)

Institute of the Pennsylvania Hospital:

Drugs

(#'s 94-90-72, 94-95-23, 94-93-00,
94-94-92, 94-93-52, 94-91-42,
94-95-32, 94-95-57, 94-95-87)

One juvenile has even been committed for a "*fake* drug overdose." (St. Francis General Hospital #11-85-22)

8. Mental health facilities are required by the Mental Health Act to receive patients *only* pursuant to the statutory provisions of the statute. However, all facilities for which data was provided admitted that, rather than using the proper provisions of the law they accept mentally ill juveniles as "general admissions." This illegal



method of commitment denies to juveniles the presently scant protections of Sections 402 and 403 and also denies them the protection of the new regulations the state has adopted. By going outside the Mental Health Act, the patients' rights (Section 423) need not be endorsed and other rights are denied, e.g., the right to be discharged when treatment is completed (Section 418), the right to leaves of absence (Section 419), the right to review by the Department (Section 420). These are the facilities which presently act in this improper manner:

Happy Hill
Don Fuanella School
Saint Mary of Providence School
Ivy Mansion for Exceptional Children
The Evans School
Clifford Nursing Home
Camp Hill Special School Inc.
Grenwich Home for Children
Refuge Home for Children
Merry Acres
Pleasant Manor Inc.

C. WITNESSES TO BE CALLED AT HEARING

1. *Expert Witnesses of Plaintiff*

1. Henry Kandler, M.D.
Assistant Professor
Einstein School of Medicine
124 E. 84th Street
New York, N.Y. 10028

2. Michael A. Ingall, M.D.
Medical Director
Providence Mental Health Center
355 Broad Street
Providence, R.I.

3. Eli Messinger, M.D.
66 W. 87th Street
New York, N.Y. 10024

2. *Other Witnesses of Plaintiff*

Kevin Bartley
Haverford State Hospital
Haverford, Pa. 19041

3. Plaintiffs' expert witnesses will testify (if the Court determines that it wishes to hear such expert testimony) regarding their experience in psychiatry, and in the treatment of juveniles, that parents and agencies often abuse their authority to commit without a hearing, that hearings would not be anti-therapeutic for juveniles, that there is no psychiatric justification for prohibiting juveniles from personally applying for admission voluntarily.

4. Evidence to be given by Kevin Bartley will include the manner of his commitment to Haverford State Hospital and the circumstances surrounding it.

5. *Expert Witnesses of Defendants*

1. Herman Staples, M.D.
24 Green Valley Road
Wallingford, Pa. 19806

2. Levon Tashians, M.D.
Institute of Pennsylvania Hospital
111 North 49th Street
Philadelphia, Pa. 19139



3. Mark Forman, M.D.
Medical Director
Child Psychiatry Division
St. Christopher's Hospital
Philadelphia, Pa.

4. Lance Wright, M.D.
Institute of Pennsylvania Hospital
111 North 49th Street
Philadelphia, Pa. 19139

5. James Gibbs, M.D.
Director of Child and Adolescent Psychiatry
Sheppard-Pratt Hospital
Baltimore, Md. 21215

6. Barbara Armstrong, M.D.
Haverford State Hospital
3500 Darby Road
Haverford, Pa. 19041

7. Aaron Smith, Ph.D.
Haverford State Hospital
3500 Darby Road
Haverford, Pa. 19041

8. Jack Kremens, M.D.
Haverford State Hospital
3500 Darby Road
Haverford, Pa. 19041

6. Defendants' expert witnesses will testify regarding their experience in psychiatry and in the treatment of juveniles, that the current procedure utilized by the State of Pennsylvania is sound and that the best interests of the juvenile would not be served if it would be otherwise.

## D. EXHIBITS TO BE OFFERED IN EVIDENCE—AGREED EXHIBITS

1. Plaintiffs' Exhibit 1—Sealed affidavits of two juvenile mental patients, describing the facts of their commitment, previously filed of record.

2. Defendants' Exhibit 1—Questionaire dated May 31, 1973 submitted to all state schools and hospitals and to all state mental hospitals.

3. Defendants' Exhibit 2—Answers to the above Questionaire submitted by all of the respondents (already filed of record).

4. Defendants' Exhibit 3—Act of October 20, 1966, entitled "The Mental Health and Mental Retardation Act of 1966", 50 P.S. §4101 et seq.

5. Defendants' Exhibit 4—Regulations, previously filed of record, adopted by the Department of Public Welfare in September of 1973 governing the commitment procedure of minors under 50 P.S. §§4402 and 4403. These adopted regulations were published in the Pennsylvania Bulletin, Volume 3, No. 37, September 1, 1973.

## E. EXHIBITS TO BE OFFERED IN EVIDENCE NOT AGREED UPON

1. Plaintiffs' Exhibit 2—Document entitled "Child's Right to Refuse Treatment," which document is the Report of the Task Force on Mental Health of Children and Youth, requested by the Department of Public Welfare Advisory Committee on Mental Health and Mental Retardation on June 15, 1973 and submitted to said Advisory Committee on August 6, 1973.

2. Plaintiffs' Exhibit 3—Affidavit of Dr. Leon Ginsburg, Dean, University of West Virginia School of



Social Work, previously filed of record. Dr. Ginsburg is leaving for South America at the beginning of August, 1974 and will be there at the time of the hearing.

3. Plaintiffs' Exhibit 4—Affidavit of Dr. Joel Finer, Monthaven Mental Health Center, 2804 Third Avenue, Bronx, N.Y. 10455. Dr. Finer will be unavailable for trial in September, 1974.

4. Defendants object to Plaintiffs' Exhibit 2 above on the grounds that it is irrelevant and object to Exhibits 3 and 4 above on the grounds that they are unable to cross-examine affiants.

## F. LIST OF DEPOSITIONS AND PORTIONS THEREOF TO BE OFFERED IN EVIDENCE

1. Deposition of Dr. Barbara Armstrong, taken on March 2, 1973. The exhibit attached to this order lists and describes those portions of the deposition which the parties have agreed to be included and those portions agreed to be excluded. The attached exhibit also indicates those portions of the deposition on which the parties are in disagreement as to which portions should be omitted and which included. The basis for these objections and disagreements is a claim by both parties that the portions are irrelevant.

2. Deposition of Dr. Max Sugar, to be taken July 31, 1974 by the Defendants. It is expected that portions to be admitted and to be excluded will be agreed upon by the parties.

## G. SEPARATE STATEMENTS OF CONTESTED ISSUES OF LAW

The parties do not agree on the contested issues of law herein. Their separate statements are given below.

1. The Plaintiffs' contested issues of law are:

a. Do the challenged portions of the Mental Health and Mental Retardation Act of 1966, and Defendants' actions in operating, enforcing and executing the same, deprive Plaintiffs and their class of liberty without Due Process of Law in violation of the Fourteenth Amendment to the United States Constitution in that Plaintiffs and their class are detained and incarcerated in mental institutions without:

1. the right to notice;

2. the right to a pre-commitment hearing;

3. the right to counsel and, if indigent, appointment of counsel;

4. the right to present evidence and testimony on their own behalf;

5. the right to subpoena witnesses and documents;

6. the right to confront and cross-examine witnesses against them and those who wish them to enter a facility;

7. the right to independent expert examination and assistance;

8. the right to be involuntarily detained only upon a decision of a judicial officer in a non-emergency context;

9. the right to be involuntarily detained only upon a decision that they are in need of care, treatment or observation, and are dangerous to themselves or others beyond a reasonable doubt;



10. the right to appeal and review, including provision for assistance of counsel and record and transcript without cost if appellant is unable to pay the cost thereof;

11. other procedural safeguards.

b. Do the challenged portions of the Mental Health and Mental Retardation Act of 1966, and Defendant's actions in operating, enforcing and executing the same, deprive Plaintiffs and their class of Equal Protection of the Laws in violation of the Fourteenth Amendment to the United States Constitution in the following manner:

1. The Act creates two classes of admittees or committees who desire to receive mental hospitalization and treatment. These classes are distinguishable only on the basis of age. One class (the juveniles) can receive such hospitalization and treatment only on the application of another party. The other class (those above the age of eighteen years) can receive such hospitalization and treatment upon their own application. There is no adequate state justification for this arbitrary classification.

2. The Act creates two classes of admittees or committees who do not desire to receive mental hospitalization or treatment. These classes are distinguishable only on the basis of age. One class (the juveniles) can be forced to receive such hospitalization and treatment without notice or hearing and with no procedural safeguards of any kind. The other class (those above the age of eighteen years) cannot be forced to receive such treatment without a judicial hearing, notice and other procedural protections. There is no adequate state justification for this arbitrary classification.

2. The Defendants submit that the contested issues of law is whether or not Section 402 and 403 of the Mental Health and Mental Retardation Act of 1966, including regulations adopted September 1, 1974, are violative of the due process and equal protection clauses of the Fourteenth Amendment to the United States Constitution.

The above constitutes the agreements and disagreements of the parties as finalized at a meeting between counsel in Harrisburg, Pennsylvania on July 25, 1974 pursuant to the Order of Court of April 19, 1974, as amended. Although the original Order specified that this final order was to be filed by July 24, 1974, by agreement of counsel, with the concurrence of Judge Huyett, it is being filed on July 26, 1974, by the Plaintiffs in accordance with Paragraph 2(d) of the Order of April 19, 1974.

Respectfully submitted,
(s) David Ferleger,
David Ferleger, Esquire
*Attorney and Guardian Ad Litem for Plaintiffs*

July 26, 1974

MENTAL PATIENT CIVIL LIBERTIES PROJECT

Suite 1407, 1315 Walnut Street
Philadelphia, Pa. 19107
215-735-8409

*With*: Peter Brown
David Norris



## EXHIBIT

*Portions of Deposition of Barbara Armstrong March 2, 1973, to be submitted to the Court*

*Portions Agreed upon by Plaintiffs and Defendants:*

Noted below, for each page of the deposition, are those portions of the deposition upon which the parties have been able to reach agreement. For these portions, the Court's direction to exclude colloquy and extraneous matters has been heeded, with success.

A second list follows, denoting those portions of the deposition upon which the parties have not been able to reach agreement, even while attempting to follow the Court's instructions.

The following abbreviations are used below: "D" for delete, "I" for include, and "L" for the line of the actual text on the particular page (spaces excluded). The number at the left margin is the page number. Where no lines are indicated, the entire page is deleted or included.

1. I
2. D after L 9
3. D
4. D
5. Disagreed (second list)
6. D
7. D; I only question by Mr. Ferleger
8. D to L 10
9. I
63. I L 15-20
64. Disagreed
65. Disagreed
66. D L 4-7, 22-24
67. I L 17-"Once . . ."-L 20
68. I 8-22
69. D L 10-11
70. I L 6
71. I L 13-16
72. I L 11-18

10. Disagreed
11. Disagreed
12. I to L 13; D L 14; I L 15, 16; D to bottom
13. I L 3-15
14. D to L 2; D L 11, 12
15. Disagreed
16. I L 6-9
17. I L 13-15; I L 22
18. Disagreed
19. D to L 6
20. I to L 6; I L 17-20
21. D to L 17
22. D L 4-9
23. I to L 5
24. I
25. D L 8-17
26. D L 22-24
27. D L 4, 7, 17-20
28. I to L 7
29. Disagreed
30. I L 20-23
31. I
32. D
33. D
34. D to L 13
35. I
36. I
37. D L 5-6, 10-21
38. D L 21-24
39. D L 7-14, 23-24
40. I to 13
73. I L 6-9, 20-24
74. I
75. D L 13-20
76. I
77. D L 16-17
78. I
79. I
80. D to L 8; I from "I would"
81. Disagreed
82. I
83. I
84. D L 21
85. I to L 10
86. Disagreed
87. Disagreed
88. Disagreed
89. Disagreed
90. D
91. D to L 5
92. I
93. D L 3-13, 17-20
94. I
95. D L 21-23
96. D L 1
97. I to L 8
98. D to L 19
99. I
100. I
101. I to L 18
102. D to L 5
103. Disagreed
104. D L 1-5, 7
105. Disagreed



41. Disagreed
42. D to L 17
43. D L 5-6
44. Disagreed
45. I
46. I to L 16
47. D L 1, 19
48. D L 20-24
49. I L 6-14
50. D L 1
51. D L 3-4
52. Disagreed
53. Disagreed
54. I 7-14, 18-24
55. I 1, 8-14
56. Disagreed
57. Disagreed
58. Disagreed
59. I L 1-22; D L 22-24
60. D
61. Disagreed
62. D L 1-2, 20-24
106. Disagreed
107. Disagreed
108. Disagreed
109. Disagreed
110. I L 1-14, 18-24
111. I
112. Disagreed
113. D to L 5
114. D L 18-19
115. D L 9-18, 22-24
116. I
117. I
118. Disagreed
119. I L 13-17
120. D to L 16
121. I
122. I
123. D to L 10
124. D L 24
125. I
126. Disagreed
127. D L 8
128. I

Noted below are those portions of the deposition upon which the parties have not been able to reach agreement. Plaintiffs' and Defendants' selected deletions and inclusions are denoted in separate columns at the right of the page, opposite the corresponding page number.

| | *Plaintiffs* | *Defendants* |
|---|---|---|
| 5. | D to L 14<br>D last 3 lines | D to L 14<br>D last 5½ lines beginning with "I . . ." |

| | | |
|---|---|---|
| 10. | I 1-4; D L 5-12; I L 13-15; D to bottom | Irrelevant |
| 11. | D to L 14 | D to L 20 |
| 15. | I L 5-19 | Irrelevant |
| 18. | D | I |
| 29. | D | I |
| 41. | I L 10-22 | D L 19-22 |
| 44. | D L 2-6; Begin at "do you"; D L 13-21 | I |
| 52. | I | Irrelevant |
| 53. | D L 3-6, 21-24 | D 21-24 |
| 56. | I to L 4 | Object |
| 57. | I L 10-24 | I 10-21 |
| 58. | D L 1 | D |
| 61. | I L 4 from "I will" to L 9 | I L 5 beginning with "I certainly . . ."- L 9 |
| 64. | D to L 21 | I L 2-7 |
| 65. | D L 4-5 | I |
| 81. | I | Irrelevant |
| 86. | I to L 7 | Irrelevant |
| 87. | D to L 21 | Irrelevant |
| 88. | D to L 22 | Irrelevant |
| 89. | I to L 8 | Irrelevant |
| 103. | I to L 9 | I to L 16 |
| 105. | I to L 16 | I to L 16; D L 16-20; I L 20-24 |
| 106. | D | I |
| 107. | D to L 14; I from "Speaking" | I |
| 108. | D L 3-5 | I L 1; D L 3-5; I remainder |



| | | |
|---|---|---|
| 109. | I to L 20 | I |
| 112. | I | I L 1-8 |
| 118. | D L 21-24 | Irrelevant |
| 126. | I | D L 14-18 |

TABLE 1 -- "VOLUNTARY" COMMITMENTS AND APPLICANT CATEGORY

| Name of State School and Hospital | Type of Commitment 402 | 403 | Other | APPLICANT FOR COMMITMENT Parent(s) | Welfare or Social Service Agencies | Court, Juvenile Court, Judge | Other family Members* | Misc. | Not Given** |
|---|---|---|---|---|---|---|---|---|---|
| Polk | 341 | [illegible] | 0 | 330 | 39 | 0 | 1 | 1 | 1 |
| Ebensburg | 601 | [illegible] | [illegible] | 596 | 25 | 0 | 0 | 0 | 0 |
| Pennhurst | 139 | 1 | [illegible] | 98 | 5 | 1 | 2 | 0 | 4 |
| Cresson | 238 | [illegible] | 2*** | 209 | 25 | [illegible] | 5 | 1 | 0 |
| Selinsgrove | 206 | [illegible] | [illegible] | 196 | 7 | [illegible] | 3 | 0 | 20 |
| Western | 291 | 8 | [illegible] | 267 | 7 | 4 | 5 | 11## | 5 |
| Laurelton | 70 | 4 | [illegible] | 58 | 6 | 0 | 2 | 1 | 0 |
| Whitehaven | 169 | 0 | [illegible] | 123 | 7 | 0 | 2 | 1 | 36 |
| Hamburg | 314 | 0 | [illegible] | 200 | 12 | 0 | 2 | 0 | 0 |

* "Other family members" include grandparents, uncles, aunts, brothers.
**There is no explanation for the facilities' so frequently leaving blanks in their replies.
***These two persons are transfers from other facilities; they are listed as "voluntary" but no applicant with appropriate legal section is given.
## These 11 persons' applicants are listed as "Entrustment Agreement."

All entries refer to the number of cases involved.





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TABLE 1a -- "VOLUNTARY" COMMITMENTS AND APPLICANT CATEGORY

| Name of State School or Hospital | Type of Commitment 402 | 403 | Other | APPLICANT FOR COMMITMENT Parent(s) | Welfare or Social Service Agencies | Court, Juvenile Court, Judge | Other Family Members | Misc. | Not Given |
|---|---|---|---|---|---|---|---|---|---|
| Dixmont | 1 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | 3 |
| Allentown | 73 | [illegible] | [illegible] | 50 | 5 | 0 | 1 | 0 | 27 |
| Hollidaysburg | [illegible] | 3 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | 1 | 0 |
| Harrisburg MH & R Center | [illegible] | [illegible] | [illegible] | 1 | 0 | 0 | 0 | 0 | 0 |
| Somerset | [illegible] | [illegible] | [illegible] | 6 | 2 | 0 | 0 | 0 | 0 |
| Fairview | [illegible] | [illegible] | [illegible] | [illegible] | 0 | 0 | 0 | 0 | 0 |
| Philadelphia | [illegible] | [illegible] | [illegible] | 1 | [illegible] | 0 | 0 | 1 | 1 |
| Warren | 11 | [illegible] | [illegible] | 6 | 2 | 0 | 0 | 2 | 2 |
| EPPI | [illegible] | [illegible] | [illegible] | 15 | 4 | [illegible] | 0 | 0 | 0 |
| Embreeville | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | 0 | [illegible] |
| Norristown | [illegible] | [illegible] | [illegible] | 10 | 0 | [illegible] | [illegible] | 2 | 0 |
| Torrance | [illegible] | 5 | 0 | 3 | 0 | 0 | 1 | 0 | 1 |
| Wernersville | 21 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | 21 |
| Haverford | 13 | 134 | 0 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | 197 |
| Clark Summit | [illegible] | 3 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| Retreat | [illegible] | 4 | 0 | 3 | 0 | 0 | 1 | 0 | 0 |
| Eastern | 211 | [illegible] | 5 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | 215 |
| Harrisburg St. Hosp. | 8 | 7 | 0 | 7 | 2 | 0 | 1 | 4 | 1 |
| Danville | 22 | 1 | 0 | 17 | 5 | 0 | 0 | 0 | 1 |
| Mayville | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |
| | 4 | 35 | 0 | 34 | 0 | 5 | 0 | 0 | 0 |

TABLE 2 -- COURT COMMITMENTS AND APPLICANT CATEGORY

| Name of State School and Hospital | Type of Commitment 406 | Not Given** | Other | APPLICANT FOR COMMITMENT Parent(s) | Welfare or Social Service Agencies | Court, Juvenile Court, Judge | Other Family Members* | Misc. | Not Given** |
|---|---|---|---|---|---|---|---|---|---|
| Polk | 19 | 0 | 0 | 1 | 7 | 9 | 0 | 1[a.] | 0 |
| Ebensburg | 12 | ? | ? | ? | ? | ? | ? | ? | 12 |
| Pennhurst | [illegible] | [illegible] | 3[b.] | 34 | 4 | 1 | 0 | 0 | 11 |
| Cresson | [illegible] | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Selinsgrove | | 0 | 0 | 2 | 1 | 0 | 0 | 0 | 0 |
| Eastern | 5 | 0 | 5[c.] | 2 | 3 | 4 | 0 | 1[d.] | 1 |
| Laurelton | 6 | 0 | 0 | 4 | 1 | 0 | 0 | 1[e.] | 1 |
| Whitehaven | [illegible] | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 |
| Hamburg | 20 | 0 | 0 | 16 | [illegible] | 0 | ? | 0 | 0 |

* "Other family members" include grandparents, uncles, aunts, brothers.
** There is no explanation for the facilities' so frequently leaving blanks in their replies.
a. The petitioner was the Superintendent of Polk.
b. These were 3 transfers under Section 416.
c. These 6 were under the 1951 law.
d. The County Mental Health Administrator.
e. "Deputy Administrator of Juveniles and Misdemeanants."

All chart entries refer to the number of cases involved.

TABLE 2a -- COURT COMMITMENTS AND APPLICANT CATEGORY

| Name of State School or Hospital | Type of Commitment 406 | Not Given | Other | APPLICANT FOR COMMITMENT Parent(s) | Welfare or Social Service Agencies | Court, Juvenile Court, Judge | Other Family Members | Misc. | Not Given |
|---|---|---|---|---|---|---|---|---|---|
| Allentown | 3 | 0 | | 3 | 0 | 0 | 0 | 0 | 0 |
| Hollidaysburg | 1 | 0 | | 1 | 0 | 0 | 0 | 0 | 0 |
| Harrisburg MH & R Center | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Somerset | 1 | 0 | 0 | | | | | | 1 |
| Fairview | 0 | 0 | 4 | 0 | 0 | 3 | 0 | 0 | 1 |
| Philadelphia | 7 | 0 | 0 | | | | | | |
| Warren | 26 | 0 | | 0 | 0 | 0 | 0 | 0 | 26 |
| EPPI | 1 | 0 | | 1 | 0 | 0 | 0 | 0 | 0 |
| Norristown | 13 | 0 | 0 | 1 | 0 | 1 | 0 | 8 | 0 |
| Torrance | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Wernersville | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 11 |
| Haverford | 31 | 0 | 31 | 0 | 0 | 0 | 0 | 0 | 68 |
| Retreat | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |
| Harrisburg St. Hosp. | 10 | 0 | 0 | 3 | 4 | 0 | 0 | 3 | 0 |
| Mayview | ? | ? | ? | ? | ? | ? | ? | ? | ? |
| Danville | 6 | 0 | 0 | ? | ? | ? | ? | ? | 6 |
| Woodville | 8 | 0 | 0 | 0 | 0 | 7 | 0 | 0 | 1 |
| Eastern | 23 | 0 | 0 | ? | ? | ? | ? | ? | 23 |
| Clark Summit | 4 | 0 | 0 | ? | ? | ? | ? | ? | 4 |

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TABLE 3

NUMBER OF JUVENILES ADMITTED DURING 1972 TO FACILITIES

| Name of State School and Hospital | TYPE OF COMMITMENT 402 | 403 | 406 | Not Given* |
|---|---|---|---|---|
| Polk | 33 | 0 | 0 | 0 |
| Ebensburg | 26 | 0 | 0 | 0 |
| Pennhurst | 11 | 0 | 30 | 0 |
| Cresson | 41 | 0 | 0 | 0 |
| Selinsgrove | 17 | 2 | 0 | 0 |
| Western | 55 | 3 | 2 | 0 |
| Laurelton | 29 | 0 | 2 | 0 |
| Whitehaven | 87 | 0 | 2 | 0 |
| Hamburg | 18 | 0 | 3 | 0 |

*There is no explanation for these omissions in the data supplied by Defendants.

**TABLE 3a**

**NUMBER OF JUVENILES ADMITTED DURING 1972 TO FACILITIES**

| Name of State School and Hospital | TYPE OF COMMITMENT 402 | 403 | 406 | Not Given |
|---|---|---|---|---|
| Allentown | 65 | 23 | 2 | |
| Norristown | 17 | 11 | 15 | |
| Hollidaysburg | 0 | 2 | 1 | |
| Sommerset | {28} | | 0 | |
| Farview | 0 | 0 | 0 | 0 |
| Philadelphia | 9 | 2 | 4 | |
| Harrisburg MH & R Center | 0 | 1 | 0 | 0 |
| Warren | 4 | 0 | 12 | 0 |
| EPPI | 17 | 2 | 1 | 0 |
| Torrance | 0 | 4 | 2 | 0 |
| Wernersville | 12 | 0 | 3 | 0 |
| Haverford (to May 1, 1973) | 10 | 113 | 24 | 0 |
| Retreat | 3 | 1 | 1 | 0 |
| Harrisburg State Hospital | 7 | 13 | 14 | 0 |
| Mayview | 0 | 0 | 0 | (1 awaiting transfer) |
| Woodville | 4 | 29 | 7 | 0 |
| Dixmont | 0 | 0 | 1 | 0 |
| Eastern | 93 | 0 | 20 | |
| Embreeville | 10 | 0 | 10 | |
| Clark Summit | 1 | 1 | 2 | |
| Danville | 21 | 0 | 11 | |



TABLE 4

OBJECTIONS TO TREATMENT*

| Name of State School and Hospital | Objected at or after Commitment | Capacity to Object## Yes | No |
|---|---|---|---|
| Polk | 0 | -- | -- |
| Ebensburg | 3 | Remarks on record | |
| Pennhurst | 0 | -- | -- |
| Cresson | 0 | -- | -- |
| Selinsgrove | 16 | 16 | 0 |
| Western | 15 | 6 | 8 |
| Laurelton | 7 | 3 | 4 |
| Whitehaven | 0 | -- | -- |
| Hamburg | 0 | 0 | 0 |

*All the data here are questionable both in terms of their incompleteness and the fact that the replies are frequently qualified by such terms as "no objection on the record" or "don't know."

**The question marks ("?") indicate no reply by the facilities.

## The capacity to object is determined solely by the facility without any reported judicial determination of incompetency for that purpose.

## SUMMARIES OF SELECTED PATIENTS

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#402

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---

Hon. Wm. C. Ferguson

---

IN THE COURT OF QUARTER SESSIONS OF THE PEACE, OF THE COUNTY OF PHILADELPHIA

---

JUVENILE COURT

---

April 4, 1913

Committed to the custody of Eastern Pennsylvania State Institution for the Feeble-Minded and Epileptic, 15 years of age, Feebleminded.

Subject to order of Court.

[Seal]

Arthur D. Brown
*Pro-Clerk*

---

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Eastern Pennsylvania State Institution for the Feeble-Minded and Epileptic

ADMISSION OF MINOR

APPLICATION

In the case of ———————————— of Phila. ———— 19—.
Received 2/1/10
Admitted Mar. 19/10

———

STATE INSTITUTION FOR THE FEEBLE-MINDED AND EPILEPTIC
Spring City, Pennsylvania

———

APPLICATION FOR THE ADMISSION OF A CHILD UNDER TWENTY YEARS OF AGE

———

*To the Board of Trustees of the Eastern Pennsylvania State Institution for the Feeble-minded and Epileptic:*

I, the undersigned Secretary, resident of Philadelphia, County of Philadelphia, State of Pennsylvania, respectfully request that my Ward,* named ———————— and aged 12 years, be admitted to your Institution.

(Signed) [Illegible]
*Secretary*

Let Every Question Be Answered as Fully as Possible

Question — Answer

1. What is the child's name? ————————.
2. What is the date of the child's birth? Sept. 12th, 1897.
3. Where was he born? Philadelphia.
4. Was he born at the full period of gestation? Yes.
5. Were there any extraordinary circumstances attendant upon the delivery? If so describe them. No.



6. Was the delivery natural or instrumental? Natural.
7. Was the child injured during delivery, especially about the head? No.
8. What has been the general health and the bodily conditions of the child? Fair.
9. What is now the general health of the child? Good.
10. Does he walk? Yes.
11. At what age did he begin to walk? About 18 mos. old.
12. At what age was any mental peculiarity first noticed? About 9 years age.
13. In what manner did this peculiarity first manifest itself? In strange actions.
14. Has the child ever had any accident or injury of any kind? If so, describe it fully, stating age at time of occurrence, and what effects if any, remain. Was sunstruck between age 3 & 4.
15. [Illegible] No.
16. [Illegible] —
17. [Illegible] No.
18. [Illegible] No.
19. [Illegible] √
20. [Illegible] √

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21. [Illegible]
22. Is consciousness apparently lost at each attack?

23. Are the attacks increasing in frequency or becoming more severe?

24. Do the attacks occur more frequently by day or night?

25. What is the greatest number of attacks the child has ever had in twenty-four hours?

26. Was the father of the child subject to fits or tuberculosis? No.

27. Was the mother of the child subject to fits or tuberculosis? No.

28. Was there any known pecularity in the family of the father of the child? That is, were any of the grandparents, parents, uncles, aunts, brothers, sisters or cousins blind, deaf or insane, or afflicted with any infirmity of body or mind?

29. Is there any peculiarity in the form or size of the head? If so, describe. No.

30. Is there any infirmity of body, or limbs, any paralysis, or any striking pecularity? If so, describe fully. No.

31. Is he of average size for his age? Yes.

32. Is he active and vigorous? Does he run about and notice things, or is he indolent? Is active & vigorous—Can notice readily.

33. Is he nervous? Yes.

34. How is his appetite? Is he gluttonness? Is gluttonness.

35. What is the state of the sense of taste? Is he particular about what he eats, or will he swallow things without regard to taste? Seems to swallow without regard to taste

36. Are sight and hearing good? Yes.

37. Is he fond of music? Yes.



38. Does he recognize color? Yes.

39. What color does he know by name? Nine.

40. Does he recognize form? No.

41. Does he notice pictures to distinguish them? No.

42. Does he understand language? To a certain extent.

43. Does he understand a command? At times.

44. Can he do errands? Sometimes.

45. Does he talk? Yes.

46. At what age did he commence to talk? √

47. Is there any peculiarity or defect of speech? If so, describe. Very little.

48. [Illegible] No.

49. [Illegible] [Illegible]

50. [Illegible] No.

51. [Illegible] No.

52. [Illegible] from 1 to 10.

53. [Illegible] Fair.

54. [Illegible] when excited wets his clothing.

55. [Illegible]

56. Can he dress and undress himself? Yes.

57. Can he bathe himself? Yes.

58. Does he use a spoon, or knife and fork? Yes.

59. Can he tie his shoestrings in a regular knot? Yes.

60. Can he do any work; and what kind? Can assist around the house.

61. Does he hide, break or destroy things? Yes.

62. Does he sleep well and quietly? No.

63. Is he obedient? No.

64. Is he passionate, or of good temper? Of good temper.

65. Has he any other unfortunate habits? Is a chronic runaway.

66. How does he amuse himself? With anything—just like a boy.

67. What cause has beeen ascribed for his mental deficiency?

68. Has he had the usual diseases of childhood—measles, scarlatina, whooping cough, etc.? Yes.

69. Has he ever been vaccinated? Yes.

70. Where was the father born? Ireland.

71. What was the general bodily condition and health of the father; was he vigorous and healthy, or the contrary? Vigorous & healthy.

72. Were all his senses perfect? Yes.

73. Was he always a temperate man? No.

74. About how old was he when the child was born?

75. If dead, at what age did the father die, and of what disorder?

76. Where was the mother of the child born? Ireland.

77. What was the general bodily condition of the mother of the child; strong and healthy, or the contrary? Strong & healthy.

78. Were all her senses perfect? Yes.

79. Was she always a temperate woman? Yes.

80. About how old was she when the child was born?

81. How many children had she before the aforesaid child was born? One.

82. How many since? Five.

83. How many have died, and of what disease? Two—No information.

84. Was there, or is there, any deformity of body, or mental deficiency in the other children? If so, describe fully. All are normal.



85. What was the state of the mother's health during the time she was pregnant with the child? Good.

86. Was she subject to any bodily injury or severe sickness, or to any extraordinary [illegible] emotion or fright, great sorrow or the like? No.

87. [Illegible] No.

88. [Illegible] About 4 yrs. died from [illegible].

[Illegible portion]

94. State fully what estate or property the child has? None.

95. State fully what estate or property the father has? None.

96. State fully what estate or property the mother has? None.

97. What is the father's residence? (?)

98. How long has he resided there?

99. From what place did he remove to his present residence?

100. What has been the father's occupation? Laborer.

101. What is the mother's residence? Deceased.

102. How long has she resided there?

103. From what place did she remove to her present residence?

104. Do the father and mother reside together?

105. Who has custody of the child?

106. What is the guardian's residence?

107. When was the guardian appointed? July 19th, 1905.

108. By what court was the guardian appointed? By Magistrate [illegible].

109. State what amount the parent or parents or legal guardian is or are able to pay? Nothing.

110. Give name and post office address of person to whom correspondence is to be directed?

(Signed) Wm. H. A. Neills
*Secretary*
Certificate of Magistrate or Judicial Officer
[Illegible]

---

## CERTIFICATE OF DIRECTORS OR OVERSEERS OF THE POOR

We, the undersigned, ———————— of the Poor for the Poor District of Phila. Pa., hereby certify that we have examined the circumstances of the above-named child and his parents, and find that the said child has the following property and estate, to wit: none, and that his parents have the following property and estate to wit: none. And we further certify that the said child has not an estate of sufficient value to defray the expenses [illegible] of his maintenance in the Eastern Pennsylvania State Institution for the Feeble-minded and Epileptic; and that the parents of the said child are not of sufficient financial ability to defray such expense*; and that the ———————— ————————of the said child is — able to pay ———————— dollars per month towards such expense.

And we further certify that the legal settlement of said child is in the said district.

Witness our hands the 28th day of January 1960.

(Signed) [Illegible]

[Illegible] when properly filled out to be mailed to Henry M. Weeks, M.D. Supt., Spring City, Pa.



## CERTIFICATE OF PHYSICIAN

I, the undersigned, certify that I have examined the within named ———————— and find that he is by reason of being feeble-minded, incapable of receiving instruction in the common schools of the state, [illegible] bodily health and no contagious disorder.

(Signed) [*Illegible*], M.D.

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## CAMERON, ELK, McKEAN, POTTER COUNTIES CHILD GUIDANCE CLINIC

October 30, 1971
(b. 1/23/58)

### PSYCHIATRIC SUMMARY

is now a powerfully built 13 year 10 month old adolescent who has suffered from a mixed type seizure disorder and mental retardation since surviving a nearly fatal nephritis at age 4 years.

He has been on anticonvulsant medications since that age. He has also been placed on several tranquillizing drugs without notable response (Thorazine, Librium).

was first known to me when he was seen psychiatrically, in another clinic, on 5/21/70 on a school referral.

At that time, residential placement was strongly recommended, but was not carried out.

However, such placement should in no way, be delayed in present circumstances which are marked by very sudden, explosive, rage reactions in which he attacks others and for which he has no recollection.

In one instance this summer, while at camp, it took five persons to restrain .

One of the five, a counsellor, lost several teeth in the process.

On several instances, he has physically attacked his mother who, on one occasion, was saved when a neighbor called dad who, with 17 year old brother, have been able to restrain during his wild rages only because of their combined strength.

In view of the foregoing, it is most urgently recommended that be placed in the Polk State School for the protection of , himself, and of others who might become victims of his unforseeable, sudden episodes of violence.

John T. Pitkin, M.D.
John T. Pitkin
*Psychiatric Consultant*

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13 173

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CAMERON, ELK, McKEAN, POTTER COUNTIES
MH/MR CLINIC

133-135 North Bennett Street,
Bradford, Pennsylvania 1670

September 15, 1971

PSYCHOLOGICAL EVALUATION

*Name*: is a 13-7 year old white single male residing with his parents at . He had "nepheritis" at age 4. He receives home tutoring.

*Reason for Testing*: Parents wish to process papers for Polk State School and Hospital.

*Date Tested*: September 15, 1971



*Instruments Used*: Wechsler Intelligence Scale for Children
Wide Range Achievement Test
Bender Gestalt
Vineland Social Maturity Scale

*Observations*:

related well to the examiner. He was courteous and displayed some social amenities. His physical movements were slow, while no gross physical handicaps were noted. His speech was slow, but was clear and distinct. He understood instructions well and seemed to enjoy the various test items.

*Results*:

| *Scaled Scores* | | *Scaled Scores* | |
|---|---|---|---|
| Information | 6 | Picture Completion | 4 |
| Comprehension | 4 | Picture Arrangement | 2 |
| Arithmetic | 6 | Block Design | 2 |
| Similarities | 4 | Object Assembly | 0 |
| Vocabulary | 0 | Coding | 0 |

Verbal I.Q. 62
Performance I.Q. 44
Full Scale I.Q. 48

is functioning in the Moderate Range of Mental Retardation. It is to be noted that his verbal functioning is at a higher level. While he has difficulties with abstraction and creativity, he can remember factual material and reason in a concrete manner. His visual figure-ground perceptions indicate organicity. His scores in the Performance tasks were depressed by his slow motor activity.

Wide Range Achievement Test

| | |
|---|---|
| Reading Level | 3.6 |
| Arithmetic Level | 4.2 |

Results from psychologicals done in 1966 indicated reading at 1.3 and arithmetic 1.8. It seems that has been able to benefit from his home tutoring.

Vineland Social Maturity Scale, with his mother as informant, estimated a social age around 9.0. He does well with self-help skills, but lags behind in socialization and any remunerative or creative tasks.

David Lee
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13 173

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CREDIT REPORT

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COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF REVENUE
BUREAU OF INSTITUTIONAL CORRECTIONS

Date: 12/20/71

Institution: Polk State School & Hospital
Patient's Name:
Legal Residence:
Street & Number:
City or Town:
County & State: McKean County, Pa.
Patient's Number: 13,173
Birth Date: 1/23/58
Veteran Yes ☐, No ☐; Vet. Serial No.
Dependent of Vet. Yes ☐, No. ☐; Vet. Claim No.
Admission Date: 12/20/71
Soc. Sec. No.: RA will apply
Medicare: Plan "A" ☐ Plan "B" ☐ Number of days previously used under Plan "A":



Marital Status: Single ☒ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Number of Children:
Wife or Husband's Name & Address:
Patient's Parents:
Name: Father: ; Street No.: ; Address: ; City and State: ; Social Security No.: 208-20-5908; Deceased Date:
Name: Mother: ; Street No.: ; Address: ; City and State: ; Social Security No: 188-22-9341; Deceased Date:
Legally Liable: Spouse ☐ Parent ☒ Child ☐ Guardian ☐ Trustee ☐ Committee ☐
Name: ; Street and Number: same as above; City and State:
Legally Liable's Employers Name and Address: ; Weekly Salary:
Insurance: (1) Patient's ☐ (2) Parent's ☐ (Check)
Insurance Company Name: ; Address: ; Health: ; Life: ; Other: ; Amount:
Real Estate: (1) Patient's ☐ (2) Spouse's ☐ (3) Parent's ☐ (4) Son's or Daughter's ☐
Type: ; Address: ; Owner's Name: ; Value:
Personal Property: Stocks ☐ Bonds ☐ Savings and Checking Account ☐ Mortgages ☐ Other ☐ (Explain):

Signatures:
Person Interviewed: ; Relationship: mother & Father; Date: 12/20/71; Interviewer and Date: Charles R. Bruner, Revenue Agent

A. Eligibility: ; Classified: Part Pay; Date: 12/20/71; Revenue Agent: [Illegible]

13 173

Street City

Other Remarks: (Any information that was not shown on the reverse side because of space limitations, may be shown in this section.)

Send all correspondence to:

Father signed Part Pay agreement 12/20/71 for $17.00.

13 173

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Nov. 26, 1971

APPLICATION FOR ADMISSION TO A MENTAL HEALTH OR MENTAL RETARDATION FACILITY

Mental Health and Mental Retardation Act of 1966
(Sections 402, 403, 404 and 405)

Type of Admission

☒ Voluntary Admission (Complete Parts I and III)

☐ Voluntary Commitment (Complete Parts I and IV)

☐ Emergency Detention (Complete Parts I, V and VI)

☐ Medical Certification (Complete Parts I, II, VI and VII, if patient is mentally retarded also complete Part VIII)

*To Be Completed by Facility*

Name of Facility: POLK STATE SCHOOL AND HOSPITAL

Admission Date: Decenber 20, 1971

Case Number: 13,173

PART I. PERSONAL DATA



Patient's Name (Last, First, Middle):

Maiden Name:

Aliases:

Social Security No.:

Address (Street, Town, State): Pa.

Sex: ☒ Male; ☐ Female

Age on Admission: 13

Date of Birth: Month: 1; Day: 23; Year: 1958

Education: (Enter highest grade completed inc. college & advanced study):

Marital Status: ☐Married; ☐ Widowed; ☐ Divorced; ☐ Separated; ☒ Never Married

Occupation: None

Income (Total gross annual family income to nearest thousand dollars): $——

Number of Persons Dependent on Income:

Previous Psychiatric Service:

☒ None
☐ Pa. State Mental Hosp. (24 hr. care)
☐ Private Mental Hospital
☐ VA Hospital
☐ Pa. State Mental Retardation Facility
☐ Psychiatric Unit General Hosp.
☐ Other Inpatient Care
☐ Psychiatric Day-Night Care
☐ Private Mental Retardation Facility
☐ Private Psychiatrist
☐ Outpatient Clinic
☐ Other Outpatient

If patient recently received treatment from an above noted facility and/or physician, please enter name(s):

---

Name, Address and Relationship of Responsible Relative:

Telephone No.:

Date: 11-23-71

_____

Signature of Applicant

PART II.

AFFIDAVIT

This affidavit must be sworn to or affirmed before a person authorized to administer oaths.

(Only Required for Medical Certification Admission)

State of _____ )
) ss
County of _____ )

_____ being duly sworn/affirmed according to law doth depose and say that the facts set forth in the above application are true to the best of his knowledge and belief.

Sworn/affirmed to and subscribed before me this — day of _____ A.D. 19—.

_____

(Signature of Applicant)

I certify that the signature to the foregoing petition is genuine.

_____

Signature of Person Administering Oath

13 173



PART III.

APPLICATION FOR VOLUNTARY ADMISSION
(Under provisions of Section 402)

_____

(Patient's Name)

I hereby make application for voluntary admission to Polk State School and Hospital for ☐ myself ☒ above named patient. I understand that I may leave the facility at any time or may remove the above minor patient from the facility at any time.

_____

Signature of patient or applicant

11-23-71
Date

Father
If not patient—relationship to patient

NOTE: If the patient is under 18 years of age, the application must be signed on his behalf by the patient's parents, or guardian, or other person in loco parentis.

13 173

_____

13173 12,560

McKEAN COUNTY

Admitted 12-20-71

Filed: 11/16/71
Accepted: 11/16/71
For Admission: 12/20/71

## POLK STATE SCHOOL AND HOSPITAL

I-21

### PSYCHOLOGICAL EXAMINATION

Name: ; Birthdate: 1/23/53; No. 13,173

Admitted: 12/20/71; Examined: 12/30/71; Psychologist: H. W. Lamb

Practical Knowledge: Fair

Psychometrics:

Date: 12/30/71; Kind: SIT; CA: 13-11; MA or SA: 9-2; IQ or SQ: 66; Status & Degree of Retardation: ; Code

Date: 12/30/71; Kind: Raven; CA 13-11; MA or SA: 10-9; IQ or SQ: 77; Status & Degree of Retardation: Mild; Code

Date: 12/30/71; Kind: WRAT: Reading 4.4; Arithmetic 3.9

Date: 12/30/71; Kind: Bender-Gestalt: PMA 8-0

Projectives:

Date: 12/30/71; Kind: Rorschach; Qualifying Personality Reaction: ; Code

Date: 12/30/71; Kind: Hand Test; Qualifying Personality Reaction: without qualifying phrase; Code

### PSYCHOLOGICAL IMPRESSIONS

——— is a convulsive young man 13-11, who is dangerously assaultive and it is not clear to what extent his behavior reflects his moods, possible psychomotor seizures, or bullying. He also uses drugs to control seizures. His outbreaks appear to be cyclical and he seems to exhibit more than normal STrength during their course. The Hand Test showed a marked dependency and a possible passive-aggressive orientation, but control appeared adequate and there were no signs of significant pathology.



The Bender-Gestalt Test showed a perceptual-motor age level below his mental level ascertained on intelligence tests, and there were some 'irritable' dots and indications of poor fine control consistent with a convulsive history.

The Rorschach was very unusual and not at all characteristic of mental retardation but contained many confabulations, human movement, contaminations and dysphoric content. The extent to which contaminations and confabulations reflect a psychotic process or simply mental retardation is debatable, but there is a definite aura of schizo-affective tone.

——— behavior is a more serious obstacle to his return to the community than his retardation. He has a combative posture that is easily set off by cyclical tensions paralleling his confabulatory processes and these may trigger psychomotor-like attacks.

13 173

## CREDIT REPORT

### COMMONWEALTH OF PENNSYLVANIA
### DEPARTMENT OF REVENUE
### BUREAU OF INSTITUTIONAL COLLECTIONS

Date: November 18, 1970

Institution: Polk State School

1. Patient's Name:

Legal Residence:

Street & Number:

City or Town:

County & State: Lawrence County, Pa.

Patient's Number: #13,077

Birth Date: 12/13/56

Veteran: Yes ☐, No ☐; Vet. Serial No.

Dependent of Vet.: Yes ☐, No ☐; Vet. Claim No.

Admission Date: 11/17/70

Soc. Sec. No.

Medicare: Plan "A" ☐ Plan "B" ☐ Number of days previously used under Plan "A"

Marital Status: Single ☒ Married ☐ Separated ☐ Divorced☐ Widowed ☐ Number of Children:

Wife or Husband's Name & Address:

2. Patient's Parents:

Name: Father: ; Street No.: last address; Address: ; City and State: ; Social Security No.: ; Deceased Date:

Name: Mother: ; Street No.: ; Address: ; City and State: ; Social Security No.: ; Deceased Date:

3. Legally Liable: Spouse ☐ Parent ☒ Child ☐ Guardian ☐ Trustee ☐ Committee ☐

Name: ; Street and Number: As above; City and State:

Name: ; Street and Number: As above; City and State:

Legally Liable's Employers Name and Address: ; Weekly Salary:

4. Insurance: (1) Patient's ☐ (2) Parent's ☐ (Check)

Insurance Company Name: ; Address: Health: ; Life: ; Other: ; Amount:



Real Estate: (1) Patient's ☐ (2) Spouse's ☐ (3) Parent's ☐ (4) Son's or Daughter's ☐

Type: ; Address: ; Owner's Name: ; Value:

Personal Property: Stocks ☐ Bonds ☐ Savings and Checking Account ☐ Mortgages ☐ Other ☐ (Explain):

Signatures:

Person Interviewed: ; Relationship: Mother; Date: 11/17/70; Interviewer and Date:

A. Eligibility: ; Classified: Indigent; Date: ; Revenue Agent:

13 077

Name Street City

Born: 9/11/52 Married
10/31/54
12/ 5/59
10/16/65
3/ 6/68

Other Remarks: (Any information that was not shown on the reverse side because of space limitations, may be shown in this section.)

Send all correspondence to:

Also: Mr. Darrell Black, Caseworker

Tenantment Relations Office Housing Authority
Lawrence County
New Castle, Pa.

13 173

## APPLICATION FOR ADMISSION TO A MENTAL HEALTH OR MENTAL RETARDATION FACILITY

Mental Health and Mental Retardation Act of 1966
(Sections 402, 403, 404 and 405)

Type of Admission

☐ Voluntary Admission (Complete Parts I and III)
☐ Voluntary Commitment (Complete Parts I and IV)
☐ Emergency Detention (Complete Parts I, V and VI)
☒ Medical Certification (Complete Parts I, II, VI and VII, if patient is mentally retarded also complete Part VIII)

*To Be Completed by Facility*

Name of Facility: POLK STATE SCHOOL AND HOSPITAL
Admission Date: Nov. 17, 1970
Case Number: 13,077

PART I. PERSONAL DATA

Patient's Name (Last, First, Middle):
Maiden Name:
Aliases:
Social Security No.:
Address (Street, Town, State): 16101
Sex: ☒ Male; ☐ Female
Age on Admission: 14
Date of Birth: Month: 12; Day: 13; Year: 56
Education: (Enter highest grade completed inc. college & advanced study): Special Ed.
Marital Status: ☐ Married; ☐ Widowed; ☐ Divorced; ☐ Separated; ☒ Never Married
Occupation: N.A.



Income (Total gross annual family income to nearest thousand dollars): Active Public Assistance
Number of Persons Dependent on Income: N.A.
Previous Psychiatric Service:

☐ None
☐ Pa. State Mental Hosp. (24 hr. care)
☐ Private Mental Hospital
☐ VA Hospital
☐ Pa. State Mental Retardation Facility
☐ Psychiatric Unit General Hosp.
☐ Other Inpatient Care
☐ Psychiatric Day-Night Care
☐ Private Mental Retardation Facility
☐ Private Psychiatrist
☒ Outpatient Clinic √
☐ Other Outpatient

If patient recently received treatment from an above noted facility and/or physician, please enter name(s):

_____

Name, Address and Relationship of Responsible Relative: Mother
Telephone No.:
Date: October 27, 1970

_____
Signature of Applicant

PART II.

AFFIDAVIT

This affidavit must be sworn to or affirmed before a person authorized to administer oaths.

(Only Required for Medical Certification Admission)

State of Pennsylvania )
) ss
County of [Illegible] )

_____ being duly sworn/affirmed according to law doth depose and say that the facts set forth in the above application are true to the best of his knowledge and belief.

Sworn/affirmed to and subscribed before me this 27th day of October A.D. 1970.

_____

(Signature of Applicant)
Mrs. Shirley Belknap Kerr
Signature of Person Administering Oath
Notary Public
Union Township,
Lawrence County
My Commission Expires Oct. 10, 1974

Commonwealth of Pennsylvania
Department of Public Welfare
MH, MR-1-6/69

PART III.

NA

APPLICATION FOR VOLUNTARY ADMISSION
(Under provisions of Section 402)

_____

(Patient's Name)

I hereby make application for voluntary admission to

_____

(Name of Facility)



for ☐ myself ☐ above named patient. I understand that I may leave the facility at any time or may remove the above minor patient from the facility at any time.

_____

Signature of patient or applicant

_____

Date

_____

If not patient—relationship to patient

NOTE: If the patient is under 18 years of age, the application must be signed on his behalf by the patient's parents, or guardian, or other person in loco parentis.

PART IV.

NA

APPLICATION FOR VOLUNTARY COMMITMENT
(Under provisions of Section 403)

_____

(Patient's Name)

I hereby make application for voluntary commitment to _____ for ☐ myself

(Name of Facility)

☐ above named patient. I understand that I must give at least ten (10) days notice in writing to the director if I desire to leave the facility or remove the above named minor patient from facility.

_____

Signature of patient or applicant

_____

Date

_____

If not patient—relationship to patient

Witness

Address of Witness

NOTE: If the patient is under 18 years of age, the application must be signed on his behalf by the patient's parent, or guardian, or other person in loco parentis.

(This commitment is not to exceed 30 days)

PART V.

NA

APPLICATION FOR COMMITMENT FOR EMERGENCY DETENTION
(Under provisions of Section 405)

Application for emergency detention of the patient is hereby made to:

Administrator County

I believe that _____ is mentally
(Name of Patient)
disabled and that immediate emergency detention is necessary.

State your reasons for believing that the patient is mentally disabled (Include the acts or threats which give you reason to believe emergency detention is necessary.):

(Signature of Applicant)

Date



APPROVAL FOR TAKING INDIVIDUAL INTO CUSTODY AND DISPOSITION

(Name of Patient)

☐ Shall be examined by _____
(Name of Physician)
and if required admitted to _____
(Name of Facility)

☐ Shall be admitted direct to _____
(Name of Facility)
for a period not to exceed ten (10) days.

(Signature of Administrator or Delegate)

Date

NOTE: Upon receipt of the approved application and certificate the Director may receive and detain the patient for emergency detention for a period not to exceed ten (10) days.

CERTIFICATE OF PHYSICIAN

[Illegible]

IF PATIENT IS MENTALLY ILL—Admission MUST be made within thirty (30) days of the first certifying examination.

IF PATIENT IS MENTALLY RETARDED—Admission MUST be made within three (3) months of first certifying examination.

FOR EMERGENCY DETENTION — Admission MUST be made immediately after certifying examination.

Name of Patient:

Birth: 12-13-56
Date of Examination: 10-30-70
Address of Patient:

HISTORY OF ILLNESS AS GIVEN BY APPLICANT AND OTHER RELEVANT INFORMATION INCLUDING REPORT OF PSYCHOLOGIST IF PATIENT IS MENTALLY RETARDED

(Form is attached for Report of Psychologist)

Been taken care of by Childrens Hospital in Pittsburgh, Pa since 8 Months old.

I.Q. of 34.—Mental retardation

1967: Surgical [Illegible]

Physical and Mental Findings at Time of Examination:

Physical Complaint: pain in lower walls of [Illegible]

Obesity: 181 lbs.

[Illegible] of legs

Poor coordination of legs—[Illegible] Reflexes knee.

Retarded—childish in response

I certify that I am licensed to practice medicine or osteopathy in Pennsylvania and that I have examined the patient with care and diligence within one week prior to the date of this certification.

In my opinion the patient is:

☐ Mentally Ill
☒ Mentally Retarded
☐ Not Mentally Disabled

(REQUIRED ONLY FOR EMERGENCY DETENTION UNDER SECTION 405)

☐ Patient in Need of Emergency Detention



☐ Patient Not in Need of Emergency Detention

G. S. Cunningham, M.D.
Signature of Physician
16101
Address of Physician

Date: 10-30-70

---

AFFIDAVIT

This affidavit must be sworn to or affirmed before a person authorized to administer oaths
(Only Required for Medical Certification Admission)

State of Pennsylvania )
) ss
County of Lawrence )

G. S. Cunningham being duly sworn according to law doth depose and say that the facts set forth in the above application are true to the best of his knowledge and belief.

G. S. Cunningham
(Signature of Physician)

Sworn/affirmed to and subscribed before me this 10 day of Nov. A.D. 1970.

I certify that the signature to the foregoing petition is genuine.

Howard B. Hanna,
Signature of Person Administering Oath
Notary Public
[Illegible]
[Illegible]

CERTIFICATE OF PHYSICIAN

IF PATIENT IS MENTALLY ILL—Admission MUST be made within thirty (30) days of the first certifying examination.

IF PATIENT IS MENTALLY RETARDED—Admission MUST be made within three (3) months of first certifying examination.

Name of Patient:
Date of Examination: 10/31/70
Address of Patient: Pa.

HISTORY OF ILLNESS AS GIVEN BY APPLICANT AND OTHER RELEVANT INFORMATION INCLUDING REPORT OF PSYCHOLOGIST IF PATIENT IS MENTALLY RETARDED

(Form is attached for Report of Psychologist)

[Illegible]: I.Q.—34.
History: birth trauma
Physical and Mental Findings at Time of Examination:
Retarded

[Illegible] normal except for obesity—has definite hernia—secondary sex characteristics beginning

I certify that I am licensed to practice medicine or osteopathy in Pennsylvania and that I have examined the patient with care and diligence within one week prior to the date of this certification.

In my opinion the patient is:
☐ Mentally Ill
☒ Mentally Retarded



☐ Not Mentally Disabled

Theodore A. Gravel, Jr., M.D.
Signature of Physician
New Castle, Pa.
Address of Physician
[Illegible]
New Castle, Pa. 16101

Date: 10/31/70

---

AFFIDAVIT

This affidavit must be sworn to or affirmed before a person authorized to administer oaths

(Only Required for Medical Certification Admission)

State of Pennsylvania )
) ss
County of Lawrence )

Theodore A. Gravel being duly sworn according to law doth depose and say that the facts set forth in the above application are true to the best of his knowledge and belief.

Theodore A. Gravel, Jr.
(Signature of Physician)

Sworn to and subscribed before me this 10 day of Nov. A.D. 1970.

I certify that the signature to the foregoing petition is genuine.

Howard B. Hanna
Signature of person administering Oath

REPORT OF PSYCHOLOGIST

Patient's Name:
Birthdate: 12/13/56
Date of Examination: 12/23/69

BACKGROUND INFORMATION

MATURATION (Significant lag in growth and development): was a short, obese, 13 year old boy, with an appearance of retardation. He wore glasses and has obvious tongue thrust. He cooperated well until his tasks became more difficult, then he became angry and petulant. His speech was extremely limited, appearing to have a difficult time thinking of names of objects. He frequently made motions to designate the use of the object, or he emitted sounds related to the objects pictured.

——— ——— ☐ over

SOCIAL ADJUSTMENT: ———, a severely retarded boy, at the present time is living with his grandparents. He seems to have been manageable in his mother's home up until a year ago. However, this was accomplished by her occasionally farming her other children to relatives. Mother shows considerable immaturity and inadequacy in handling children; therefore, she was quite uncapable of handling [Illegible].

He attended special education classes in New Castle. This training does not seem to have altered his behavior sufficiently so that he could be maintained at home. The patient's basic problem is one of retardation. In the last year, however, he has begun to "act out" aggressively and is becoming interested in "sex". ☐ over

NAMES OF TESTS AND RESULTS: Stanford-Binet Intelligence Scale Form L-M—earned a mentally 3½ years. For his chronological age of 13, the IQ earned was



34. The range of testing extended from the 3-year level where he passed all of the test items to the 4½ year level where he failed the test items. (NO Tests attempted at higher levels because of his angry response to the pressure of more difficult tasks. It's possible that he could have passed some additional test items.

DIAGNOSIS (AAMD Classification): ——— ——— was a severely retarded boy, 13, IQ 34, mental age 3½ years. He was particularly inept in language expression & appeared to have a greater understanding than he was able to communicate verbally. Responded to pressure with infantile anger. Although it was impossible to give him extensive personality testing, he indicated considerable hostility which he has been reported to have released in fire setting & attacks on other children. Emotional control & confused orientation are undoubtedly more of a threat in the home where he experiences more rivalry & opportunity to perform. Placement in a residential (over) DIAGNOSIS, Cont.—center for the severely retarded should be arranged as soon as possible.

Virginia Fulcomer, Ph.D
Clinical Psychologist

Record the Person's Level of Development for Each of the Following:

1. Attribute: Self-Help Skills: Severely Sub-Average: ; Moderately Sub-Average: x; Mildly Sub-Average: ; Average: ; Above Average: .

2. Attribute: Attentional Development: Severely Sub-Average: ; Moderately Sub-Average: x; Mildly Sub-Average: ; Average: ; Above Average: .

3. Attribute: Perceptual Functioning: Severely Sub-Average: ; Moderately Sub-Average: x; Mildly Sub-Average: ; Average: ; Above Average: .

4. Attribute: Psychomotor Functioning: Severely Sub-Average: ; Moderately Sub-Average: ; Mildly Sub-Average: x; Average: ; Above Average: .

5. Attribute: Communication Skills: Severely Sub-Average: ; Moderately Sub-Average: ; Mildly Sub-Average: x; Average: ; Above Average: .

6. Attribute: Concrete Cognitive Functioning: Severely Sub-Average: ; Moderately Sub-Average: x; Mildly Sub-Average: ; Average: ; Above Average: .

7. Attribute: Abstract Cognitive Functioning: Severely Sub-Average: ; Moderately Sub-Average: x; Mildly Sub-Average: ; Average: ; Above Average: .

8. Attribute: Vocational Functioning: Severely Sub-Average: ; Moderately Sub-Average: x; Mildly Sub-Average: ; Average: ; Above Average: .

9. Attribute: Personality Integration: Severely Sub-Average: x; Moderately Sub-Average: ; Mildly Sub-Average: ; Average: ; Above Average: . □ over

Virginia Fulcomer, PhD. Clinical Psych.
Psychologist
Mental Health Clinic of Lawrence County

Prepared by:
Louis F. Palumbo
Social Services Director
Lawrence County Housing Authority

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LAWRENCE COUNTY
Admitted 11-17-70

Filed: 6/20/69
Accepted: 10/13/70
For Admission: 11/17/70



13077

---

W.S.S.H.

00015

Reason for placement:

"If ———————— remains for any length of time in this home, I think there is a very good chance of mother breaking down, the marriage ending in separation, father's health failing and the adolescent daughter being pushed into a premature marriage to escape an unhappy home."

Diagnosis (July 20, 1960):

Mental Status: Severe-Idiot I.Q.—10

Diagnosis: Mental deficiency with congenital cerebral spastic paralyses

Cause: Congenital cerebral defect

Somatic diseases: Spastic quadriplegia; Cleft soft palate; Microcephaly; Dental caries

Body condition on admission: Impaired

Behavior disorders: None

00067

Reason for placement:

"Since maternal grandparents have come to live with the family, this has presented serious problems. The maternal grandmother needs constant care but the maternal grandfather has been unable to help and acts as if he hates everyone. The older sister, ————————, has also had problems in adjusting to the situation. Mother was said to be close to a nervous breakdown and could no longer cope with both ———————— and the maternal grandmother."

Diagnosis (October 1, 1963):

*AAMD*

Mental Retardation associated with Encephalopathy due to anoxemia at birth

Visual handicap

Hearing handicap

Major motor seizures

Choreoathetosis

Spastic quadriplegic

*APA*

Chronic Brain Syndrome associated with birth trauma (anoxemia due to cord being wrapped around neck)

Mental deficiency ($x^4$)—Severe

OO131

Reason for placement:

"It was the worker's impression that this boy was in need of placement because now he has become uncontrollable. The parents realized that at their age they will have increasing difficulty in coping with their son."

W.S.S.H.

00131 (cont'd.)

Diagnosis (December 5, 1963):

*AAMD*

Mental Retardation associated with mongolism

Level II—Adaptive Behavior—Trainable (?)

*APA*

Chronic Brain Syndrome associated with pre-natal influence, mongolism, without qualifying phrase

Mental deficiency ($x^4$)—Severe



00144

Reason for placement:

"The father described her as hyperactive, but the mother disagreed and said that she was only active. Though the parents stated that she was well accepted at home, they felt that now that she is entering pubescence, it will be better for her to be admitted at this time. The maternal aunt who had been caring for her was away and since she was the one against placement, the parents felt that this was the time to arrange for placement. The brothers, though they love ————, are uncomfortable in her presence."

Diagnosis (December 27, 1963):

*AAMD*

Mental retardation associated with encephalopathy due to anoxemia at birth

Spastic paraplegia

Level II—Adaptive Behavior—Trainable

*APA*

Chronic Brain Syndrome due to unkown cause without qualifying phrase

Mental deficiency ($x^4$)—Severe

Re-evaluated diagnosis (March 18, 1974):

*AAMD*

Trauma or physical agent-perinatal hypoxia

Hydrocephalus, secondary

Spasticity with paraplegia, moderate

Adaptive Behavior-Level III (1973 Revised Classification)

00281

Reason for placement:

". . . she had become a management problem to both her parents and the community."

Diagnosis (August 26, 1964):
*AAMD*

Mental Retardation due to uncertain cause with the functional reaction alone manifest
Major motor seizures (history)
Level III—Adaptive Behavior

W.S.S.H.

00281 (cont'd.)

Diagnosis (cont'd.):
*APA*
Mental deficiency, idiopathic, severe bordering on moderate

00288

Reason for placement:

Poor family situation—mother does not get along with patient well. The family is ". . . afraid that the mother would have another nervous breakdown if it (placement) was not done soon."

Diagnosis (September 2, 1964):
*AAMD*

Mental retardation, cause unknown, with the structural reaction manifest
Hearing and visual handicap
Tremor-head
Level II—Adaptive Behavior—Trainable child
*APA*
Chronic Brain Syndrome due to unknown cause
Mental deficiency ($x^4$)—Severe



## PSYCHOLOGICAL REPORT

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*Name*:
*Date of Testing*: 7/11/72
*Date of Birth*: 9/20/61
*Chronological Age*: 10 years, 10 months
*Referred by*: The patient's parents
*Reason for Referral*: Interim short term placement at Polk State School and Hospital during the family's vacation.

*Tests Administered*: Wechsler Intelligence Scale for Children and the Draw-a-Person Test

*Test Behavior*:

was extremely cooperative and friendly throughout the complete testing session. He brought his Raggedy Ann doll along with him and related to this doll as if it were possessing human capabilities. , or as he is called , calls this doll Raggy and several times throughout the session asked Raggy if she were comfortable or if she knew what the test answers were. is an affectionate child who goes out of his way to express positive affection and his liking for people. One cannot help but return this affection to him.

*WISC*:

On this scale achieved a full scale IQ of 54, a verbal 10 of 52 and a performance IQ of 64 which places him in the Mental Defective range of intellectual functioning. The verbal tests ranged in scale score from 0 through 4 with the low scale score of 0 being found on the Comprehension and Similarities subtests. As such, has

extremely defective abilities relating to the ability to evaluate past experiences and to abstract and generalize. The scale score of 4 was found on the [illegible].

13 212

—2—

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The performance tests ranged in scaled scores from 4 through 7 with the low scaled score of 4 being found on Picture Arrangement, Block Design and Coding. The high scaled score of 7 was found on Picture Completion which suggests very high, at least high for this individual, ability relating to visual recognition and differentiation. Even though this child has low intellectual abilities he seems to have developed well within his excellent social and family environment and it can be anticipated that he will develop in the future along these similar lines.

*Draw-a-Person Test*:

Since indicated a desire to draw he was provided with paper and asked to draw a picture of a person. immediately indicated that he wanted to draw Raggy and proceeded to do such. His difficulty developed in the drawing of legs and he wanted this examiner to draw them for him. When the responsibility was placed upon him he made an attempt and his drawing seems to be at least recognizable of human form. Using the Goodenough Scoring System it was found that has a mental age of 7 years, 3 months which computes into an IQ of 67. This IQ seems to be consistent with the results found from the WISC.

*In Summary*:

is a child almost of 11 years who has intellectual abilities of a Mental Defective nature. Verbal abilities seem to be low although they do point towards some development and the performance abilities seem to be of a higher nature. During the testing session it was noticed that does have a fairly extensive vocabulary and he is able to combine words into moderate length sentences. Since there is a lack of community facilities which can provide emergency placement it is being recommended that this child be placed at Polk State School and Hospital for a period of 1 to 2 weeks so that the other family members can go on a family vacation. Considering the future it is this examiner's —3— opinion that will be able to continue in the special education programs in the public schools up until the age of 21 and that sheltered workshop placement can be considered from that point on.

should be offered the opportunity for family counseling so that they can provide the best possible educational and vocational experiences for their son.

T. W. Morris
TWM
Coordinator of Mental Retardation Services

TWM:pr



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For Professional Use Only

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[Illegible]

Institution: Polk State School and Hospital
Patient's Name:
Legal Residence:
Street & Number:
City or Town:
County & State: Crawford, Penna.
Patient's Number: #13,212

Birth Date: 9/20/61
Veteran: Yes ☐, No ☐; Vet. Serial No.
Dependent of Vet.: Yes ☐, No ☐; Vet. Claim No.
Admission Date: 7/20/72
Soc. Sec. No.:
Medicare: Plan "A" ☐ Plan "B" ☐ Number of days previously used under Plan "A":
Marital Status: Single ☒ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Number of Children:
Wife or Husband's Name & Address:
Patient's Parents:
Name: Father: ; Street No.: ; Address: ; City and State: ; Social Security No.: 207-22-3626; Deceased Date:
Name: Mother: ; Street No.: ; Address: ; City and State: ; Social Security No.: ; Deceased Date:
Legally Liable: Spouse ☐ Parent ☒ Child ☐ Guardian ☐ Trustee ☐ Committee ☐
Name: ; Street and Number: ; City and State:
Legally Liable's Employers Name and Address: ; Monthly Salary: $685.00
Insurance: (1) Patient's ☐ (2) Parent's ☐ (Check)
Insurance Company Name: ; Address: ; Health: ; Life: ; Other: ; Amount:
Real Estate: (1) Patient's ☐ (2) Spouse's ☐ (3) Parent's ☒ (4) Son's or Daughter's ☐
Type: Frame (5 rm.); Address: ;



Owner's Name: ; Value: $19,500.00
Personal Property: Stocks ☒ Bonds ☐ Savings and Checking Account ☒ Mortgages ☒ Other ☐ (Explain):
Stocks:
Mortgage:
Signatures:
Person Interviewed: ; Relationship: Parents; Date: 7/20/72; Interviewer and Date: Anita Ghering—7/20/72
A. Eligibility: ; Classified: Part Pay; Date: 7/20/72; Revenue Agent: [Illegible]
Born: 12/16/65
Other Remarks: (Any information that was not shown on the reverse side because of space limitations, may be shown in this section.)
Patient was brought to Polk from home in and was accompanied by both parents.
Telephone number of parents:
Correspondence to be sent to:

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APPLICATION FOR ADMISSION TO A MENTAL HEALTH OR MENTAL RETARDATION FACILITY
Mental Health and Mental Retardation Act of 1966
(Sections 402, 403, 404 and 405)

Type of Admission

☒ Voluntary Admission (Complete Parts I and III)
☐ Voluntary Commitment (Complete Parts I and IV)
☐ Emergency Detention (Complete Parts I, V and VI)
☐ Medical Certification (Complete Parts I, II, VI and VII. If patient is mentally retarded also complete Part VIII)

*To Be Completed by Facility*

Name of Facility: POLK STATE SCHOOL AND HOSPITAL

Admission Date: July 20, 1972
Case Number: 13,212

PART I. PERSONAL DATA

Patient's Name (Last, First, Middle):
Maiden Name:
Aliases:
Social Security No.:
Address (Street, Town, State):
Sex: ☒ Male; ☐ Female
Age on Admission: 10
Date of Birth: Month: 9; Day: 20; Year: 61
Education: (Enter highest grade completed inc. college & advanced study):
Marital Status: ☐ Married; ☐ Widowed; ☐ Divorced; ☐ Separated; ☐ Never Married
Occupation:
Income (Total gross annual family income to nearest thousand dollars):
Number of Persons Dependent on Income:
Previous Psychiatric Service:

- ☐ None
- ☐ Pa. State Mental Hosp. (24 hr. care)
- ☐ Private Mental Hospital
- ☐ VA Hospital
- ☐ Pa. State Mental Retardation Facility
- ☐ Psychiatric Unit General Hosp.
- ☐ Other Inpatient Care
- ☐ Psychiatric Day-Night Care
- ☐ Private Mental Retardation Facility



- ☐ Private Psychiatrist
- ☐ Outpatient Clinic
- ☐ Other Outpatient

If patient recently received treatment from an above noted facility and/or physician, please enter name(s):

_____

Name, Address and Relationship of Responsible Relative: [Illegible]
Telephone No.: [Illegible]

_____
Signature of Applicant

Date: July [Illegible]

PART II.

AFFIDAVIT

This affidavit must be sworn to or affirmed before a person authorized to administer oath.

(Only Required for Medical Certification Admission)

State of _____ )
) ss
County of _____ )

_____ being duly sworn/affirmed according to law doth depose and say that the facts set forth in the above application are true to the best of his knowledge and belief.

Sworn/affirmed to and subscribed before me this — day of _____ A.D. 19—.

_____
(Signature of Applicant)

I certify that the signature to the foregoing petition is genuine.

_____
Signature of Person Administering Oath

Commonwealth of Pennsylvania
Department of Public Welfare
MH/MR-1-10/70

PART III.

APPLICATION FOR VOLUNTARY ADMISSION
(Under provisions of Section 402)

_____

(Patient's Name)

I hereby make application for voluntary admission to Polk State Mental Hospital for ☐ myself ☒ above named patient. I understand that I may leave the facility at any time or may remove the above minor patient from the facility at any time.

_____

Signature of Patient or Applicant

Date: July [Illegible]

Mother

If not patient—relationship to patient

NOTE: If the patient is under 18 years of age, the application must be signed on his behalf by the patient's parents, or guardian, or other person in loco parentis.

CRAWFORD COUNTY

Admitted 7/20/72

Filed: 7/17/72
Accepted: 7/17/72
For Admission: 7/20/72



POLK STATE SCHOOL AND HOSPITAL

I-21

PSYCHOLOGICAL EXAMINATION

Name: ; Birthdate: 9/20/61; No. 13,212

Admitted: 7/20/72; Examined: 7/26/72; Psychologist: H. W. Lamb

Practical Knowledge: Poor

Psychometrics:

Date: 7/26/72; Kind: SIT; CA: 10-10; MA or SA: 5-9; IQ or SQ: 53; Status & Degree of Retardation: ; Code

Date: 7/26/72; Kind: Raven; CA: 10-10; MA or SA: 5-9; IQ or SQ: 53; Status & Degree of Retardation: Mild; Code

Projectives:

Date: ; Kind: ; Qualifying Personality Reaction: without qualifying phrase; Code

PSYCHOLOGICAL IMPRESSIONS

_____ is an educable mongolian boy who should be placed in an educable rather than a trainable program. He is more active than the typical mongolian physically and more alert mentally. He was seen at the Outpatient Clinic by Joseph O'Mara in January, 1966; and at that time he had a social quotient of 60 and was ruling the roost at home. While autonomy for mongolians is questionable, has the capacity to participate in many educable and trainable activities, and an active program appropriate for his active state could keep him functioning at a higher level than is usual for mongolians and might minimize the stigmata and physical characteristics typical of mongolism.

13 212

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

No. 72-2272 Civil Action

Kevin Bartley, et al.,
*Plaintiffs*

v.

Jack B. Kremens, et al.,
*Defendants*

Philadelphia, Pennsylvania
July 31, 1974

PRETRIAL ORAL EXAMINATION OF DR. MAX SUGAR

(1) Pretrial oral examination of Dr. Max Sugar, a witness, taken on behalf of the defendants, pursuant to Notice, at 1300 State Office Building, Philadelphia, Penna., on Wednesday, July 31, 1974, commencing on or about 9:33 o'clock A.M., before Marvin Dinter, Official Court Reporter.

Present:

David Ferleger, Esq., Attorney for Plaintiffs.

Barry A. Roth, Esq., Assistant Attorney General, Attorney for Defendants.

Also Present:

Ron Hartman, Law Clerk.



(2) DR. MAX SUGAR, being first duly sworn, was examined and testified as follows:

THE COURT REPORTER: Dr. Sugar, would you please state your full name and address, for the record.

THE WITNESS: Dr. Max Sugar. My address is 3625 Chestnut Street, New Orleans, Louisiana, 70115.

BY MR. ROTH:

Q. What is your profession, please?

A. I am a psychiatrist.

Q. And where did you receive your training?

A. I went to Medical School at the University of Toronto where I got my degree in Medicine and an internship in New Orleans, and I had my residency training in psychiatry and child psychiatry in New Orleans at Louisiana State University and at Tulane University and in New Orleans Child Guidance Clinic.

Q. Are you Board Certified?

A. Board Certified in General Psychiatry and in Child Psychiatry.

Q. Have you written any articles or books?

A. Yes. I have written about 35 articles and I am currently (3) editing a book which will be published this year.

Q. Do some of the articles pertain to child psychiatry?

A. Yes.

Q. Do you have any speciality within the field of psychiatry?

A. Yes, I am a Child Psychiatrist. I also have a special interest in adolescent psychiatry. I have been very

active with the American Society for Adolescent Psychiatry, and I am the immediate past president thereof.

Q. How long have you been practicing?

A. Well, I have been a physician since 1948, 26 years.

Q. And could you indicate what your current position is.

A. I am Clinic Professor of Psychiatry at Louisiana State University in New Orleans, and I am in private practice in New Orleans.

(Whereupon, Mr. Ferleger entered the deposition room.)

MR. FERLEGER: Would you please read back the questions and answers for me, please.

(Whereupon, the preceding questions and answers were read back by the court reporter.)

BY MR. ROTH:

Q. Dr. Sugar, have you been appraised of the two sections of the Pennsylvania Mental Health and Mental Retardation Act of 1966, namely, Sections 402 and 403 which are under attack in this lawsuit?

(4) A. Yes.

Q. Now, the procedure in those sections primarily permit a juvenile aged 15 or under to be voluntarily institutionalized by his parent or guardian or person standing in a loco parentis while adults less than 18 may release themselves.

Also you have been provided with the additional safeguards which are afforded juveniles which, in part, permits notice to be given them for the reasons of their commitment and the accessibility of an attorney in an event a



juvenile, aged 13 or older, objects to his admission or subsequent thereto.

Now, would you, Doctor, reveal, according to your expert opinion, why juveniles should be treated procedurally different from adults.

A. Yes.

I think that in adolescence you still have a person who has not completed their development physically, continuantly, emotionally and their thinking ability and intellectual ability is not developed yet. They don't have the experience of the world and of what goes on as the adult has.

MR. FERLEGER: Did you say adolescent?

THE WITNESS: Yes. I was talking about the youngster between 13 and 18. I was calling that the adolescent.

The adolescent usually has a lot of hormonal changes, secondary sexual changes, growth changes, epiphyseal changes; some of these don't get completed almost until their (5) twenties, so that there is a—this is still a human being that is still needing care, guidance, attention by parents. They are not able to look after themselves. They have an awful lot of unsettled issues, emotionally among other things, so they are still in need of parental care, parental responsibility; and although at times this is difficult in the adolescent years, it should still be available.

Part of the problem comes up early in the adolescent with the adolescent problem about one continuing to be separate and wanting to be away from home and have his own independence and be quite

autonomous and is still unable to do so. He can't make a living; doesn't have a skill or trade or profession, and the only way that the possibilities can be received is through parental responsibility being carried out and allowing the youngster the opportunity for growth and development to the maximum possible form.

In talking about the normal adolescent who has all these things still to achieve, although he is closer to being an adult and is not a child, we still have the same kind of things that go on in terms of need to be taken care of just as with a child, although they are different. The needs are still there.

Now, with an adolescent who has some other things going on, such an intellectual retardation or has problems of an emotional type, he has some special extra needs. Therefore, (6) he may not be in as good a position to judge things as the ordinary adolescent is whose judgment is not that well settled or that good until he has gone through the adolescent period. So, he still is, even more than a normal adolescent, needs parental guidance, responsibility and so on to be continued until he has passed that point and, if he is incapable of functioning, then he needs even more safeguards which are provided by parents, physicians or whatever institution the youngster may need to be placed in for further help.

BY MR. ROTH:

Q. Doctor, with regard to these procedures, the plaintiffs feel that a judicial hearing prior to a juvenile commitment would best serve the juvenile's interest. Could you, please, comment in your professional opinion as to the



effects of a judicial hearing prior to commitment of a juvenile?

A. Yes.

The point at which a juvenile becomes subject to being considered for admission to some kind of psychiatric institution usually is based on his having some kind of obvious symptoms that lead the people around him to become concerned, become aware that something is going on that needs attention. So that this may be awhile or it may be a very short time after the need arises, but there is some problems, something that is erupting, and the youngster needs some help since he is unable to manage it or do something that could be done to settle it, (7) and if he needs professional help, then this needs to be given to him as soon as possible.

Now, when someone has a symptom that brings someone else's attention to it, it is usually because he wants some help.

Now, the adult, if he wants help, can deal with his own mixed feelings about going to the doctor or not going to the doctor or getting to see the dentist or not getting to see the dentist. He has the understanding and the experience of those situations. An adolescent who is disturbed emotionally has not only the problem of the assessment of his need, ordinarily he also has the problem of assessing it in the light of distortions that he has due to his emotional illness, so when someone has somehow impinged on the people around him to the point that they are saying this person needs some kind of help or this person should be off the streets or this person needs to be getting some help, it is because the person who is having the trouble has finally caused enough trouble or enough distress to those around him so that they respond with concern to do something about it.

Now when that happens, the youngster could dissemble and say nothing is the matter and just try to hide it. This doesn't mean that there is nothing the matter. It means he may be upset about the issue of facing the conflicts; it doesn't mean he doesn't want to have some help. It means that he has some mixed feeling about it; so that when finally somebody (8) in society, whether his family or whether it is the police or the school, finally somebody says this youngster needs help and asks something about it, there is usually a feeling of relief on the youngster's part that finally somebody has heard him and someone is going to do something to help him.

He may object, but that isn't unusual in adolescence for a switf turnabout in feelings and attitudes about something; yet if the person who is charged with the responsibility takes that responsibility, there is a lessening of anxiety, a lessening of the panic state. It may be a lessening of feelings of going out of control or doing something destructive to those around him by acting on this appropriately. Then the youngster is placed in a situation where his needs can be taken care of or begin to be taken care of through the proper, professional approaches.

So, if a youngster needs to be placed in a psychiatric institution because he is threatening suicide or because he is out of control or feels he is going out of control, or feels he is in a panic about to do something disastrous, if somebody says that they are going to make arrangements for him to go into the hospital, then there is some feeling of comfort about it because somebody is going to take care of what he needs to be taken care of.

Now, if there is an intervention of a delay this, I think, would perhaps promote the youngster to having some (9) further difficulties instead of having comfort



about being placed in the proper professional situation. He would have the added anxiety of having a judicial hearing instead of treatment, and he would have the added anxiety of putting off getting something done and to be placed in a proper institution.

I would feel that kind of barrier would add to the youngster's difficulties rather than minimize or decrease them.

Q. Assuming there were a hearing, could you see any trauma attaching to the juvenile when present at the hearing?

A. In several ways: first, there would be the delay which I just spoke of, plus the threat of the court which would sometimes stir up a lot of feelings in youngsters, especially about authority and law and incarceration and so on even though the judicial hearing is being held on their behalf purportedly. The youngster may not comprehend this. He is emotionally disturbed or he may have hallucinations or delusions, so you are not dealing with a person who has all his faculties available. We are dealing with somebody who has a disturbance.

If they don't have that they would not be in that position. So you have that to consider also.

You also have the fact that in a judicial hearing, unpleasant facts may be coming up about his behavior, and it is not a treatment situation. It is not a situation where someone is trying to deal with the conflicts. It is a situation where someone is trying to adjudge them and this always brings up the (10) question in a youngster's mind of right and wrong rather than dealing with his conflicts in the professional, psychiatric approach.

So, I would feel that this would be, for these reasons, adding to the youngster's difficulties.

Q. From what you say, Doctor, I assume institutionalization provides at that point—it provides immediate comfort and immediate protection for the juvenile; is that correct?

A. Yes; although the youngster may still espouse hatred of the place or object to it, he is not in a position to really assess it very well, but deep down, emotionally, he is experiencing some relief and as therapy progresses, you often hear them refer to that initial period of admission as being one of relief mixed with some anxiety. There is always anxiety about making a change. Sometimes you get anxiety about the change brought in, but the change in terms of leaving a bad situation for whatever reason, whether it is actually a bad home or whether it is a fantasy or delusion, there will be some concern about the change, but once the change is made there is relief because somebody is listening, somebody is taking care of the need.

If the need can't be taken care of where he is and he is placed in a situation where potentially the need can be taken care of, then there will be relief.

I have had youngsters express this directly when I have suggested that they need to be hospitalized for one (11) reason or another. Then they have responded with "good" or something to that effect meaning they have grasped the idea that I understand their need and that we are going to do something to try to help them and then they feel very relieved about it.

I have had youngsters when I have seen a variety of impulses about to break through. I suggest that we'd better do something about hospitalization. They feel gratified that I have taken a step towards helping them further.

For instance, if a youngster is a potential suicidal or potentially homicidal, it doesn't mean he is going to kill somebody. It means he feels like he might because he feels



like he will go out of control, or if a youngster feels like he is going to embark on a disastrous course, and when somebody finally listens and takes it seriously, then there is appreciable relief.

This is one of the problems, for instance, with youngsters who attempt suicide; that people don't hear them. They don't take notice of the signs. This is one of the areas where psychiatry has been pushing people in responsible positions to take notice of the thing; from the police officers on down to ordinary family members to note that this or that sign indicates that the youngster is asking for help; that he is suicidal and potentially many lives could be saved just by somebody hearing him at the right time and doing something about it.

(12) I had a youngster the other week who had been wearing his hair long. He came in and he had shaved his head completely, which is quite an abrupt turnabout for him. I took this as meaning something pretty serious, and in the course of the inquiry and during that session he started telling me about some illegal behavior that he was about to embark on. We talked about that, and as we talked it became apparent that he was just about to bust his bubble, so he decided he wouldn't do that illegal act, and as we talked further about the potential destructiveness that he was thinking of, he told me of a fantasy that he had the night before of taking a knife and ripping his leg, which I thought was pretty plain evidence that he needed to be in the hospital. I suggested that to him. I tried to get his family to come along and put him in the hospital. He was ready to go.

He just, I thought, should have had somebody to go in the hospital with him which is around the corner from my office.

He said that he would like to go home and pick up his radio and a couple of things.

It ended up where his father just decided that he couldn't get away from his business to come up and take the kid into the hospital, although he was agreeable to the hospitalization.

The hospital said "Fine, send him in."

(13) He ended up at—he went home. He got his stuff. En route he met some other kid and they had some pot and they had a few other things. He ended up going to the park drinking, smoking pot and while in the park with these two other kids, he ended up committing something which a policeman observed and he pulled him in on the basis of an obscenity in public, and he ended up finally getting to the hospital that evening.

He wanted somebody to make sure he got into the hospital. His father wouldn't. His mother wouldn't, but a policeman finally got him in.

He got into the Central Lockup, and the policeman escorted him into the hospital. That's a long way to get into the hospital.

The father's business had come first. If he had said that his son had come first and he needs to be taken care of, he would have gotten into the hospital that morning instead of going through all this business he did the rest of the day.

So, I think, if you follow that brief clinical vignette to sort of illustrate the point that I am making, the trouble could have been avoided 10 hours earlier.

Now, he has his name on the docket for no good reason.

His behavior that afternoon publicly could have been avoided if he had got right in when I spoke to the father (14) and told him he had to go in.



Q. Doctor, I would like you to comment upon statements that have been made regarding feelings in this case. It has been stated that juveniles "Should be afforded a hearing with counsel present to hear evidence in support of the claim that the juvenile is emotionally disturbed and that such a hearing is not traumatic, and it is much more traumatic to institutionalize a child without a hearing."

Now, can you give us your professional opinion as far as a balancing type of test, if you will, with regard to trauma affecting a juvenile prior to commitment or trauma affecting a juvenile if a hearing is not afforded.

A. I think what I have just said in the last few minutes would cover that point.

I also would think if the youngster has his need bypassed as I have just mentioned, he gets more upset instead of somebody hearing him. He needs this professionally, medically. Then he gets what he might construe as another shuffling around.

I think that perhaps the point of having a hearing may be mixed up with sentimentality. Sentimentality doesn't have any place in treatment because what you are dealing with is someone who is ill rather than romantic notions. So, if he is ill, then we start treating him by putting him in a place to take care of him. The hearing should not be put off forever if the youngster wants a hearing. Then you have that as part (15) of the law. Then he can still have recourse to that.

Q. It has also been stated, Doctor, that "Juveniles are institutionalized as mentally ill when their acts may be defined merely as juvenile delinquency."

A. Well, juvenile delinquency is a rather broad term.

Delinquency refers to an act that someone has been caught doing.

Most youngsters commit something illegal at some time. This is part of their growing up and learning right and wrong.

Most youngsters do a little stealing in their early grade school years. They do a little lying. They may break windows and run away and never be caught. You don't call them delinquent. They have never been caught. They committed something they should not have done, but the youngster who continues and doesn't learn right from wrong is having a symptom of some emotional disturbance to whatever degree it is. It is a symptom.

If he is stealing, if he is truant from school repeatedly, running away from home, these are symptoms of something emotional that has gone awry. So, the fact that it may just be a symptom doesn't mean it should be neglected. It may be a symptom of something quite serious. It may be a symptom of schizophrenia. It may be a symptom of a psychosis of another kind. It may be a symptom of something that hasn't gotten quite organized into a specific neurosis, but there is a tendency (16) toward this. It means that there has been some kind of emotional deprivation, very serious at some point in the youngster's life, and this represents his attempt to deal with it emotionally through this behavior.

Behavior has means. If we can understand the meaning of that, we understand something about the antecedent that led up to it. It may have happened 10 years before, but it is still continuing on because it hasn't gotten settled, so there is still a conflict, and the youngster's behavior is looked on as a symptomatic act of this disturbance just like if we have a fever. We know that there is something the matter in the body at that time. There is an inflammatory process. It may be due to infection. It may be due to



physical trauma, maybe malignancy. It means something is going badly someplace in the body physically.

If we have a symptomatic act of disturbed behavior whether it is called a delinquent act or whether it is called a delusion, it is an act or—it is a set of beliefs that are representative of something emotionally disturbing that person.

Q. Are you familiar with the concept enunciated in Ray Gault?

A. Yes.

Q. Doctor, that case reveals in part that "Juveniles who may be tried for a criminal act shall be afforded counsel."

An anology has been made in this case that juveniles were deprived of their liberty for a criminal act or for (17) emotional disturbance or emotionally disturbed behavior should be afforded a hearing prior to commitment.

Can you comment in your professional opinion upon the distinction between juveniles committed for criminal acts versus juveniles committed for emotional disturbances?

A. Well, sometimes you will have juveniles who have committed criminal acts because of emotional disturbances.

Sometimes you have quite a malange of the two, but as I understand that Gault case, that was a case where a youngster had a complaint lodged against him by an adult on a illegal basis and the youngster was going to be sent up to an institution without any further hearing because he was a juvenile.

There was no involvement there of medical process. There was no diagnosis made. There was no assessment of his act made medically.

There was a judicial process, and that link is a somewhat different situation when there is a medical need because the situation of that is quite—since in the hearing of the youngster's act it was adjudged as criminal without a counsel being present; in a medical situation you don't have somebody admitted to an institution just on the parent's say-so or the law officer's say-so.

You have the youngster admitted on the basis of a medical examination. Some psychiatrist has examined him. He isn't just admitted because somebody says that he should be (18) admitted.

If I send somebody into the hospital they are not admitted to the State institution because I say so. They may be presented there, but the admitting physician at the State institution still has to do his own examination, and if he says this youngster needs to be admitted, then they are admitted.

So, there is protection of a youngster because there is professional, medical opinion that is held responsible for the admission.

Q. Do you feel as a professional, of course, that you are satisfied with the voluntary admission and commitment sections of the Pennsylvania Mental Health Act and Mental Retardation—

A. It allows for the youngster's needs to be taken care of medically so he is protected that way.

I think it allows for cases where the youngster has objections to bring him to the attention of the proper authorities to a judicial hearing that is allowed. I think it allows the youngster to get the parental protection and the parental responsibilities brought to their fullest to his needs in this way. So, the youngster is protected, I think. The parental rights are protected and the youngster's rights are protected.



Q. Doctor, do you often testify in court cases?

A. I have in the past. I have not in the last few years.

Q. You have?

(19) A. I have not in the last few years, not at all.

Q. Are you being compensated for your testimony today?

A. Yes.

Q. Are there any other comments you would like to make, Doctor, knowing the nature of this case?

A. Yes.

MR. FERLEGER: I object. I think it is improper to simply ask a question inside a question. If you have a question to ask, you should ask him a question rather than asking for his general comments about the nature of the world.

MR. ROTH: You can note the objection.

The question remains.

Do you have any comments with regard to the regulation or acts involved and your feelings towards them and towards the nature of this case?

THE WITNESS: Yes. I have some other comments to make relative to the last question.

In my view, the way the current law is arranged, the youngster is protected. His needs are taken care of medically. The parental rights are not abrogated, and the due process is available in due time.

I think if he has changed in a way, that is, perhaps being suggested by the action in this case, there is perhaps a danger that the parental protection of the

youngster will be removed which means the State then becomes in charge of the (20) adolescent and raises them and that the law makes the diagnosis instead of physicians.

I think this would be a travesty for the adolescent development and medical care.

Q. Doctor, let me ask you one more question with regard to this case: It has been said that "Institutions are used as dumping grounds by parents for placing their children in institutions for reasons other than children should be placed in institutions."

MR. FERLEGER: It should be noted, for the record, that it is Chief Justice Berger of the Supreme Court who said that.

THE WITNESS: Who said what?

MR. FERLEGER: That "Families use mental institutions as dumping grounds for unwanted members of their families."

BY MR. ROTH:

Q. With all due respect for the reporter, when Mr. Ferleger wishes to cross-examine, he can, and in regard to that statement it also should be noted that that was made in a dissenting opinion by Chief Justice Berger; nonetheless it has been stated that these institutions are used as a dumping ground for parents and the parents farm their children out.

Now, do you know, from your knowledge, personal knowledge and background--would you comment about that?

Perhaps the abuses of the system and why you still (21) maintain that the system, as you know it, in Pennsylvania is sound. Would you comment on that.



A. There are a number of considerations in that. I would think that one of them has to do with the fact that physicians are liable to error just like any other humans. They can make a mistake in a diagnosis. They also may get distortions consciously, or otherwise put into the situation by the parents or by the youngsters so that they don't get a pure picture of the behavior of the symptoms of what has been going on. Those are, I would think, very small in number, and I don't think that is cause enough to change the structure.

I think it behooves us to try to be more meticulous in our diagnosistic assessment and be careful in scrutinizing the situation of each case as it comes up.

Also, I would think that by and large parents do protect their youngsters and do look after them fairly suitably because, as it stands now, we have maybe—well, let's say, roughly 10% of adolescents who are in need of some kind of psychiatric help. I think if it were that parents were not doing a pretty suitable job it might be reverse and it may be 90% would be needing psychiatric care and 10% would be functioning fairly well.

Now, on another point which I think needs to be brought in, there are situations where the family resources are just strained and they are drained and they just can't function (22) with a psychotic child or can't function with a severely retarded child, and even though ideally it might be best to have that retarded or mentally retarded child at home or a psychotic child at home, they just don't have enough resources. They are not capable themselves emotionally to handle the youngster at home, or it may be having quite a deleterious effect on other members of the family, or it may be in some way interfering with the father's being able to attend to his income-gathering pursuits, so that the family may end up on Welfare.

The father has to stay up to restrain a 15-year old boy who is quite actively destructive around the house and protect the rest of the family from his behavior that is undesirable. That means he can't go to work. So, in some of those situations, the total family functioning has to be assessed emotionally on the drain and strain on them.

There are also cases where some people just don't fit into the family scheme; the family is trying to function in one direction and the adolescent is so disturbed he just cannot fit in, and what he is doing is very much against the family function optimum. He needs treatment in a special place.

I would think that those are at times symptomatic of the youngster wanting help and being in a position where he needs to go to an institution to get help. He can't function. He can't fit in with the family for whatever reason.

So, I would think that the question of a dumping (23) ground and an abuse of that sort of thing—I don't know of any statistics that anybody has presented about that kind of thing, but I know from time to time those things have happened.

On the other hand, there are some parents who physically abuse their own children and cause skull fractures and almost kill them sometimes when they are just two or three or four years old and, there are efforts being made to try to curb that and to find those cases and take the child away from the parents because the parents aren't able to look after them properly, but still even in those extreme cases there are a very small proportion of parents, which means that there are situations where parental responsibility is not being fulfilled properly and then someone has to step in and take over.

The diagnosis of those situations is made by the doctor.



The child abuse cases are diagnosed by a doctor, and then the law is brought in to assist in proper placement of the child away from this home; not to hurt the child, but to help him survive.

So, if you take that as an extreme case, there are other cases where the youngster has to be in an institution so he can survive emotionally.

Q. Doctor, with regard to something that could be placed back in your qualifications, are you a member of any associations?

A. Yes.

(24) Q. Could you give us the names?

A. The American Psychiatric Association; The American Academy of Child Psychiatry; The American Society of Adolescent Psychiatry; The American Orthopsychiatry Association; The Southern Psychiatric Association; Orleans Parrish Medical Society; Louisiana State Medical Society; American College of Psychiatrists.

I think that's it.

MR. ROTH: I think that covers it.

I have no further questions.

BY MR. FERLEGER:

Q. Dr. Sugar, I am interested by your comments that the use of the law in mental health situations can sometimes, in your opinion, make the diagnosis, which is to occur, be accomplished by the law rather than by a doctor.

In Louisiana, are there procedures by which adults can be institutionalized in a mental hospital without a prior judicial hearing?

A. Yes. They can admit themselves voluntarily.

Q. Are there procedures for involuntary commitment for adults without a judicial hearing?

A. No. It has to be based on a diagnosis first.

Q. So, in those situations, once a doctor has made a diagnosis, the doctor makes that diagnosis to the Court and then it is a legal question whether or not the person is mentally ill or needs to be institutionalized; is that correct?

A. (25) It's based on the diagnosis given by a psychiatrist.

Q. And the decision is made by the judge?

A. Yes.

Q. So, your position is not that the Court shouldn't at all be involved in the commitment of juveniles, your position is that the Court should rely on or make use of the diagnosis and expert opinions of doctors; is that right?

A. Yes.

Q. Now, in Pennsylvania, except in emergency situations when children or adults could be committed without any delay whatsoever, when an adult is to be committed to a mental institution, the law provides that there be a prior judicial hearing.

Now, is it your opinion that that prior judicial hearing is the kind of sentimentality of the law that you mentioned with regard to children?

A. I don't think I understand your question.

Q. Do you favor, as an expert, a prior judicial hearing before an adult is committed to a mental institution?

A. No. An adult can be committed without that in case of emergency.

Q. Okay.

In the non-emergency situation—

A. Yes.

Q. Do you favor a prior judicial hearing for adults?

A. Not necessarily.



(26) I have seen some rather difficult things for the patient where there was that kind of thing and was very embarrassing, very painful to the patient.

Q. So, there are some non-emergency situations where you would feel, in your expert opinion, that there ought not to be a hearing even for an adult who is going to be committed?

A. Yes, where the adult objects and seeks counsel and wants to have the hearing in that case, this is what the law provides.

Q. Even though in your opinion it shouldn't be necessary?

A. Well, I don't think I was addressing myself to that.

Q. Well, that is the question I am asking you.

Are there situations where an adult needs hospitalization in a non-emergency situation in that kind of circumstance? Do you feel that a prior judicial hearing is appropriate?

A. I think, as I understand it, the judicial hearing in those cases, is utilized to provide admission to the adult because he refuses to accept the recommendation, so, therefore, the law is utilized to implement the diagnosis and the recommendation therefrom. So, I feel, yes, it needs to be utilized.

Q. There are situations, aren't there, where the prior hearing is used in order to incarcerate the person for the purpose of getting a diagnosis; isn't that right? Isn't that what the Pennsylvania law provides?

A. To incarcerate a person, no.

Q. For the purpose—

(27) A. Of making a diagnosis?

Q. For the purpose of obtaining a diagnosis.

A. I would hope that the diagnosis had been made before, and I don't see that that would be a proper pursuit of medicine to have someone incarcerated to make a diagnosis.

Q. Even though that is what Section 406 (a) of the Pennsylvania Mental Health Act provides? Do you think that part is improper?

MR. ROTH: Objection.

THE WITNESS: I don't understand how that comes into what I understand of the Pennsylvania Law.

BY MR. FERLEGER:

Q. Well, the Pennsylvania Law provides, doesn't it, "That a person may be committed involuntarily to a mental hospital by a Court without any diagnosis having been made; that commitment being for the purpose of making a diagnosis"?

Now, I understood your testimony to have been that in your opinion that would be an improper role for the law to play; is that right?

A. My opinion was that the youngster could be admitted.

Q. I am talking about adults now.

A. I thought the case was about adolescents.

Q. My question is about adults.

MR. ROTH: I think you are confusing the doctor in terms of what you are revealing about 406. If you want to give him a little more background, you know, so he is not (28) confused and misled in attempting to answer—

MR. FERLEGER: I will repeat my question.



BY MR. FERLEGER:

Q. Pennsylvania Mental Health—the law provides "That an adult may be committed involuntarily to a mental institution as a result of a judicial hearing prior to there having been any involvement of any psychiatrists or any medical opinion with regard to that person's condition."

That commitment under Section 406 (a) of the Mental Health Act provides for an "evaluation or a diagnosis to be made after that involuntary commitment."

A. I see.

Q. Now, I understood you to have just testified that you consider that kind of commitment or incarceration without a doctor having been involved to be inadvisable; is that correct?

A. No.

I think in that kind of situation, just as I was saying before, somebody makes enough trouble, somebody becomes enough of a nuisance, somebody takes notice and somebody takes proper action.

If somebody gets out on top of a building and says he will jump—

Q. We are not talking about emergencies.

A. Well, I am only giving you an illustration to make my point.

(29) If someone gets out on a building and says they are going to jump and they have been telling their family for weeks how depressed they are, when they get on top of the building somebody starts to notice.

So, the point is the police are brought in immediately.

Q. We are not talking about an emergency.

A. I'm talking about the fact that someone is doing something to bring him to someone's attention; that they need help, and the ordinary man in the street can tell that

somebody is walking with a limp. The ordinary man in the street can tell if someone's behavior is at odds with the usual behavior in that culture.

So, in that case somebody has some concern for someone's safety and someone's well-being. The law acts to protect the person.

Q. What is the need in that case to have a judicial hearing?

A. Since someone is taking someone else's needs as being something that needs to be attended to—

Q. Isn't the need for a juducial hearing to have an independent person find out whether the facts are as alleged?

A. If in that case you are talking about where there has not been a psychiatric evaluation—

Q. That's right.

A. The law says admit for the purpose of an evaulation since this person's behavior in some way is at odds with what the (30) usual is.

Q. Well, is there any reason for there not to be a procedure whereby the person to whose attention his symptoms came could apply for the potential patient's admission to the hospital without involving a judge?

A. Do you want to repeat that. I think I lost some of the posture there.

Q. Why not have a situation where, for example, the wife whose husband has been acting bizarre lately can apply to the mental hospital and say that my husband has been acting in such and such a way and I feel he neeeds some evaluation—would you support that kind of procedure?

A. And the patient is accepting or rejecting?

Q. Rejecting it.



A. Well, I understand that is what the law does allow for.

Q. The law does not allow that for adults. It allows that for children.

A. Yes.

Q. Is it your position that that ought to be allowed for adults as well?

A. I don't quite see what you're getting at.

Q. I'm trying to get you to answer a question.

MR. ROTH: Why don't you state the question, David.

BY MR. FERLEGER:

Q. Is it your position that the law ought to provide that (31) this hypothetical wife should be permitted to have her husband involuntarily admitted upon her application and description of his bizarre behavior to the psychiatrist at an institution?

A. No, because the psychiatrist then would do an evaluation before he would commit him.

With no evaluation before, then you have the law to allow for a judicial hearing.

Q. And if there would be an evaluation by the psychiatrist—suppose the law would provide that two psychiatrists should evaluate this involuntary husband, and if their evaluation indicated that he was mentally ill and could benefit from treatment, would it then be your position that he ought to be involuntarily committed to the institution?

A. Yes. There would be enough evidence on that basis to provide a substantive diagnosis and recommendation for hospitalization.

Q. All right.

So, based on that two-doctor recommendation, are you then supporting the law—

MR. ROTH: I object to this line of questioning because what you are trying to do with the doctor is trick him because you know of a case involving recommendations by two physicians was deemed inappropriate and unconstitutional; and Dr. Sugar is not familiar with all the Mental Health Laws of Pennsylvania. He has familiarized himself with the sections in (32) question, and I think it would be appropriate to address the sections in question and with regard to his opinion of those and the treatment of juveniles versus the treatment of adults and the procedure after safeguards afforded each. I do think it is inappropriate. I think it is misleading. To attempt to secure from Dr. Sugar an opinion, fine. He can give us his professional opinion, but with regard to things that he may feel should be acceptable which have been declared invalid, is really irrelevant to this lawsuit.

MR. FERLEGER: You know perfectly well, Barry, that it is perfectly relevant if Dr. Sugar is sincere, honest, professional opinion is that procedures ought to occur which, in fact, the laws and the courts have ruled cannot occur.

If his opinion is that certain procedures which are unconstitutional or medically proper—I think that is highly relevant to the lawsuit, and if as Dr. Sugar has stated his opinion, that doctors after doing an evaluation should have the power to involuntarily treat people, that is very relevant to the lawsuit.

This lawsuit involves equal protection as well as due process claims; the reasons for the difference in treatment of adults vis-a-vis children are also relevant.



MR. ROTH: And that should be the major focus with regard to the treatment and the procedures afforded juveniles versus afforded adults.

(33) MR. FERLEGER: You can't tell me what my question should be.

MR. ROTH: I know. But I am objecting just the same.

THE WITNESS: I would like to point out that I came here prepared to talk about juveniles and the nature of juveniles and their special needs rather than adults.

BY MR. FERLEGER:

Q. The nature and difference between juveniles and whom?

A. Adults which, I think, I explored earlier in some detail about this development and their function being incomplete.

Q. Dr. Sugar, did you come here to speak about—strike that.

MR. ROTH: Well, I object again and—

MR. FERLEGER: He can make any statement that he wants under examination by you. Right now it's cross-examination.

MR. ROTH: Fine.

There was a comment that you had made to him and he had replied to your comment and you seemed to have rapidly cut him off.

MR. FERLEGER: No. He was not replying to any comment of mine, and the record will show.

BY MR. FERLEGER:

Q. Dr. Sugar, you consider yourself an expert in adolescent psychiatry or child psychiatry as well and younger children, do you not?

(34) A. Both.

Q. You made a number of comments earlier with reference to adolescence; the fact that there are hormonal changes and growth changes, sexual changes that don't get completed until their twenties.

Now, isn't the picture a little bit different with regard to persons who were, for example, under 13, for example, not adolescents?

A. What picture?

Q. Their psychiatric status.

A. I don't know what you are asking.

Q. Well, all your comments about adolescents do not necessarily apply to younger children; isn't that correct?

A. Well, not all of them, but generally they do apply in that there is still growth. There is incomplete, physical and emotional development in younger children, and that they're in need of someone to care and be responsible for them.

Q. Now, Dr. Sugar, you commented that it is your estimate that about 10% of children need psychiatric help; is that your estimate?

A. I wasn't making an estimate. I was just using that as a figure for the purpose of my comments.

Q. What is your estimate of the number, the percentage of children who need psychiatric help?

A. I don't have an estimate of that. I don't have a figure (35) handy to give you. We can look it up in the literature, if you want.



Q. Do you have any estimate of the percentage of parents who need psychiatric help?

A. It's been stated about 10% of adults. It's been stated about 10% of children, but I couldn't give you that as a specific, accurate figure. I am just saying that is a round figure.

Q. Now, Dr. Sugar, one of the questions involved in this lawsuit is how much reliance should be placed upon the parents' evaluation or reporting of various behaviors of children.

My understanding is that it is your testimony that a substantial reliance should be placed upon the parents; is that correct?

A. On whomever they are living with. We assume for the purpose of this discussion that it is the parents.

Q. Okay.

Parents or guardians or whoever.

A. Yes.

You can also utilize data from other people that the youngsters are involved with in a substantial sort of way.

Q. Would it be your position then that commitment to an institution could be made on the application of other people besides parents, guardians of people in loco parentis?

A. Well, I think that covers it.

Anybody who is in loco parentis for that moment (36) can take action to protect the youngster.

Q. So that a child—while a child is in school, do you think he ought to be permitted to be committed by a school official without regard to the parents' wishes?

A. If the child is in a boarding school.

Q. I am talking about a regular public school.

A. I think I am not really saying that at all.

Q. You mean a boarding school?

A. Yes.

And he is in charge of loco parentis of someone else and they have responsibility to look after the child.

If the child suddenly is exhibiting bizarre behavior destructive in some way or other to himself or others, they have responsibility to exercise protection for that child.

Q. How about in the non-emergency situation? Do you think that the boarding school ought to be permitted to commit a child without the wishes of the parents?

A. I would assume that they would contact the parents. I would assume that they would do something procedurally proper to get an evaluation.

Q. I'm asking you what you feel psychiatrically.

A. Well, that's what I would feel would be the more psychiatric approach.

Q. That the parents should be contacted?

A. The boarding school should contact the parents. The (37) parents should seek appropriate evaluation and appropriate steps should be taken.

Q. It is your testimony, is it not, that you feel that parents or people in loco parentis ought to be substantially relied upon for the reporting and noting of various behaviors of the children?

A. Yes. They are the ones who have the most contact with the youngster.

He is living with them and spending most of his time with them. So, they're able to observe his behavior and changes.

Q. Now, with regard to situations in which there is disagreement between the potential patient and the parent, who is it that you think is in the position to figure out what the actual facts are? Is it the physician or psychiatrist?



A. I would think so. I would think that he should try to assess the situation from both sides and weigh the data and the observations of the youngster's mental functioning. That is what he is trained for.

Q. I might have misunderstood your testimony, but I understood you to have testified that many so-called juvenile delinquents, juveniles who commit behavior that the law considers criminal, that many of them also have emotional problems; is that right?

A. Yes.

(38) Q. Now, when a juvenile delinquent—that is a juvenile accused of some criminal act, and assuming the juvenile also has emotional problems, when a decision has to be made about what kind of rehabilitation has to be done for that child or whether, in fact, a juvenile actually did commit that behavior, who, in your opinion, should make that kind of decision?

A. I don't quite understand.

Q. Who?

A. If a juvenile has done something?

Q. When a juvenile is accused of a criminal act and that juvenile is accused in juvenile court of that criminal act, somebody has to decide whether or not that juvenile committed that act; is that right?

A. Yes.

Q. Now, the juvenile may have one story. His mother may have another story and the shopkeeper might have a third story; isn't that possible?

I didn't hear your answer.

A. I didn't answer.

Q. Well, can you answer?

A. I'm still listening to your question.

Q. My question at this point is it is possible, is it not, that the juvenile will have one story, his mother will have another story and the shopkeeper, for example, might have a third story?

(39) A. Yes, it's possible.

Q. Now, who, in your opinion, should decide which of those stories is true or what facts actually occurred?

A. I think that that is really a question that I couldn't give you an opinion on since you are saying it is a criminal case. He has been apprehended. Somebody has charged him with something. I don't think that is a medical case at that point.

Q. It is a case in which the facts have to be decided by a court; isn't that right?

A. Yes.

It is a court case at that point. It may be a medical case later.

In other words, if the assessment of what is going on leads someone to start thinking that this behavior is connected with something of an emotional disorder, then the Court would, I presume, would call on psychiatric consultants to do an evaluation.

Q. Now, Dr. Sugar, in a situation where a juvenile is accused by a parent of, let's say, acting in a hostile or retaliatory way toward a parent or juvenile and is accused of some bizarre behavior such as ripping up all the books or toys in a room or some other strange kind of behavior, isn't the first question for a psychiatrist whom this comes to the attention of, isn't the first question whether or not that behavior occurred and then if the doctor decides the behavior occurred, the question is (40) medically what is the diagnosis and the best course of action? Isn't that the process that you follow as a psychiatrist?



A. It varies according to the individual situation.

Q. In the case that I gave where a mother comes in and says that "My child has been doing all these strange and bizarre things," isn't one of the things you want to know immediately whether or not that is true?

A. Well, I would hope to get that data in the course of the evaluation. Whether I would get it in the first or ten questions is beside the point.

Q. You feel that is important information for your evaluation?

A. I would like to have the youngster's tale about what he thinks is going on.

Q. Do you understand that the purpose of this lawsuit is not to exclude psychiatrists from the picture altogether, but to have that factual evaluation done by a Court rather than a psychiatrist? Do you understand that that is the purpose of the lawsuit?

A. I really don't know what you are trying to ask me with that question.

Q. I am asking whether you understand that that is the purpose of the lawsuit.

A. To do what?

Q. To have a Court—

(41) A. Assess—

Q. —make that factual determination.

A. Of whether the kid did do or didn't do something?

Q. That is correct.

A. In a non-criminal case?

Q. That's correct.

A. And thereby seek to do what?

Q. I'm asking you if you understand that the purpose of this lawsuit is not to exclude psychiatrists?

A. "Altogether," you said.

It sounds like you are saying you want to exclude psychiatrists.

Q. Well, that is what I am trying to explain to you and clarify because, evidently, you have a misunderstanding from the defendants' counsel.

A. I didn't say that. It's my understanding—my understanding is—by the way, you are suggesting that you are delaying getting help for the youngster when he needs help. That is my point.

I was not saying what you were just quoting me as saying at all.

Q. Do you understand that the purpose of this lawsuit is to have those factual questions decided by a Court?

If that is not your understanding of the lawsuit, just answer no.

(42) A. I don't understand what you are saying really since my understanding of it was having to do with the judicial process preceding psychiatric attention.

Q. Your understanding is that this lawsuit involves a delay in obtaining psychiatric care for juveniles?

A. Yes.

Q. Now, can you explain why you feel that the emergency commitment provisions of the Pennsylvania Mental Health Act are not sufficient to get around the problem of delay in obtaining needed treatment for juveniles?

A. Well, sometimes they may not be of a level that makes them seem of an emergency basis to the casual onlooker, whether it is the family or anyone else.

Q. Isn't that also true of adults?

A. Somewhat, except that adults have more means at their disposal to do something for themselves, whereas



if a youngster is assessed as having some problems and the family takes him to a psychiatrist and the psychiatrist says this kid needs to be in a hospital—

Q. Except we are talking about adults that may be severely disturbed.

A. I really don't understand what you are getting at.

I am lost again.

Q. Dr. Sugar, —

A. I seem to have trouble following what you just said.

(43) Q. Dr. Sugar, for adults who may need or may not need psychiatric help, adults who exhibit some strange or bizarre behavior, isn't it true that in non-emergency situations delay may also be not advantageous to that adult's mental condition?

A. Yes.

Q. And it is true for children as well that delay can be a problem?

A. Yes.

Q. Dr. Sugar, are there situations where parents can be antagonistic or disruptive to what may be beneficial for their children's mental health?

A. Yes.

Q. And it's true, is it not, that there are situations where parents have psychotic children by obstructing or resisting attempts to help their children?

A. Yes.

Q. Am I correct?

A. Yes.

Q. If parents behave in that manner, you are not suggesting that they ought to be the ones who make the application to mental institutions, are you?

A. Well, usually, unfortunately they are the ones—they try to disguise the situation, but if the child goes to school or is in some way—at some times he is outside the home, it may come to someone else's attention, in which case, some (44) representative of society like the law may suggest something be done about it, or if the kid is picked up shoplifting 10 times and the parents don't see anything the matter with it, somebody may say this youngster needs to be put into a youth center by the law and then evaluated psychiatrically because the parents aren't doing something. They are not assessing the situation properly.

Q. Dr. Sugar, you have testified about a number of children who have expressed to you the anxiety and relief that children often feel about being institutionalized. For that sort of child, is it your opinion that he or she ought to be allowed to commit himself with the doctor's approval?

A. In that case the doctor takes the position of loco parentis.

Q. All right.

So, if a child wants to be given professional psychiatric assistance and if psychiatrists or a hospital believes that that child is in need of assistance, you would approve procedures whereby the child could then get assistance?

A. That's the law in terms of loco parentis. Someone would do something on an emergency basis.

Q. That would even be if the parent was one of the parents who felt that psychiatric care wasn't necessary?

A. If it was an emergency, yes.

Q. How about if it wasn't an emergency?

(45) A. Then you have a question of the law, and someone has to be responsible to take the child away from the parents to do something, just like in child abuse cases.



Q. In your expert opinion in a situation where the parents don't want treatment, but enough psychiatrists and the child both feel that treatment is needed, you feel that the law and the Court should be involved at that point?

A. For the protection of the child, yes.

Q. Thank you.

Now, it's true, isn't it, that very often parents may misinterpret behaviors of their children and feel that certain actions or what doctors would call symptoms, symptomatic behavior, are more serious than they actually are; isn't that correct?

A. Yes.

Q. There may be situations where, for example, a mother might feel that a child is attacking her even though that is not true?

A. Yes, that could be.

Q. And in a situation especially where the parents might be having some problems among themselves, that kind of information from a mother to a psychiatrist would not be very reliable; isn't that correct?

A. It would have to be weighed against the total situation, sure. The mother might be psychotic herself.

(46) Q. And it's true, isn't it, that in situations where the parents may be having problems, children may be subject to extreme deprivation of their emotional and their physical needs; isn't that right?

A. Yes.

Q. And in that kind of situation, would it be your opinion that the law ought to permit the parents to initiate institutionalization of children?

A. If the child needs institutionalization, then the parents aren't capable of making an accurate assessment. Someone needs to be able to step in to do something about it.

Q. And to make that assessment?

A. And to get the assessment done, yes. Somebody needs to evaluate that.

Q. Now, the difference in our opinions evidently, Doctor, is that you feel that solely doctors should be involved in making that assessment and the plaintiffs feel that the facts ought to be determined by the Court, and that the doctors ought to determine the psychiatric implications of those facts.

Now, in that situation where the parents might be in turmoil or conflict, where the child might have behaviors that are reported by the parent to the psychiatrist, do you see any reason in a non-emergency situation which Courts and psychiatrists couldn't work together to determine what is best for the child?

(47) A. I have no objection to the Court and psychiatrists working harmoniously together.

Q. Because in that kind of situation it is true, isn't it, that it may be impossible to get the parental cooperation that is needed for the best interest of the child?

A. It may be, in which case it may be useful to have the child put into another home or an institution where they can be evaluated and observed properly.

Q. And should that decision be made by a psychiatrist or a Court?

A. Well, that decision would initially have to be made by the law since someone has to bring it to the legal attention; the police or the Courts would have to do something to prevent the child suffering further. So, the first step would be someone noticing the behavior being not ordinary anymore and someone needs to then put the child in a safe place where they can then be evaluated.



Q. Doctor, would you, please, give me your opinion about the extent of mental illness among parents of mentally disturbed children?

A. I don't have a figure on it.

Q. Well, in your experience—

A. I don't have a figure.

Q. I am not asking for a figure. I am asking for your estimate or evaluation.

(48) A. Well, you are asking me for a figure. I can only say it does happen. I don't have figures to supply you with at this moment.

Q. Is this frequently or infrequently?

A. It depends on the nature of the situation.

If the youngster is severely ill, is a psychotic kind of youngster, there is a tendency perhaps to find a somewhat higher percentage of serious illness in the family.

Q. It would be a tendency then for psychotic children to come out of a family situation in which one or more of the other family members might also have serious mental problems?

A. There would be a tendency, yes.

It's not a genetic kind of factor at this point as far as we know, although some people feel it is, but it is not generally accepted.

Q. Isn't it true that it often happens that the behavior of adolescents which might be quite typical and normal for adolescents might frighten a family unduly?

A. No. I wouldn't think so, no.

Q. Would it frighten the family into being sort of overly concerned about the behavior of the adolescent?

A. I wouldn't think so unless there is something bizarre about the behavior—unless there is something bizarre about the parent.

Q. Well, if the behavior was so bizarre in the parent's eyes, (49) isn't it true very often that might be simply normal adolescent behavior?

A. It might be, depending on the parents' set of values and vantage points, sure.

Q. Well, if that bizarre behavior occurs, isn't it true that the parent—that the child might appear frequently more disturbed than he is and may frighten his family?

A. Potentially in that case where there is that kind of distortion in the parents.

Q. Potentially—or isn't that absolutely true?

A. I don't feel we can make that kind of comment at this point.

Q. When you wrote your article in the American Journal of Psychotherapy, "Normal Adolescent's Morning," didn't you make that very statement?

A. Do you want to quote it to me? I don't recall it.

Q. You stated that "When bizarre behavior occurs during a distortion phase the adolescent may appear to be more disturbed than he is and might frighten his family."

A. Yes.

What I was referring to there was a brief episode of something strange or unusual. The youngster has a reaction to something and he has a strange kind of response, and the parent may feel frightened about the thing temporarily.

Q. And during that temporary, frightened phase, isn't it (50) correct that the parents might decide incorrectly that the child needs psychiatric help?

A. They might; but what I was referring to in that article was a temporary phase, which means, that the usual course of it is that the parent sees a fluctuation in this.



If you recall the rest of the point I was making there it had to do with this being a fluctuating situation.

Q. Let's read it.

A. Therefore, it would be something that would become altered, and the parents might not continue with their frightened response.

Q. But the other thing that can happen—isn't it that the parents might withdraw and not even realize that the child needs help?

A. Yes, they might withdraw.

Q. And then—

A. They might overreact and say "Let's rush to the psychiatrist."

Q. If they withdraw, in that case the child would be deprived possibly of needed psychiatric help?

A. No. If that is put in the context in which I was writing, just on the basis of that kind of thing in a normal process, this would get taken care of by itself through the usual developmental processes going on. Therefore, they would not be depriving the youngster of what they are ordinarily doing for him.

Q. But it is possible, isn't it, that, for example, that (51) the child may speak to a physician and the physician may side with the parents, and in that case, the child may be deprived of help?

A. Sure. It's possible. He might not recognize the situation for what it really is, sure. Errors can be made.

Q. You stated in your article, didn't you, about the parents' bizarre behavior and that the child—that they may then withdraw or react antagonistically and miss the adolescent's real need of help through supporting controls.

If the physician identifies himself with the parents he may also lose sight of the basis of the adolescent's behavior; is that right?

A. Yes.

Q. So, there are situations then where the doctors wrongly identify them with the parents' side of the picture?

A. They identify with one or the other, and this may lead to difficulties, yes. This may happen since everyone is subject to error. That is my point.

Q. In a situation where parents are having some marital problems and—

A. Excuse me. Let me just go back to the point that I was making about withdrawing. I was referring to that in terms of a technical sense of not giving the youngster control and support. They just say something very negative or sort of say "You are on your own" or boot him out, and their response to their (52) behavior instead of realizing what it means—withdrawal means—this is not a withdrawal of monetary support. They just don't understand. They don't control and let him understand that they are still there to look after him.

Q. But there are situations where the withdrawal may result in a withdrawal of physical needs as well?

A. Yes.

Sometimes parents overreact to that degree also.

Q. You stated, as a matter of fact, in your article "Divorce and Children" in the Southern Medical Journal that with reference to divorce "The subsequent guilt or change in their matrimonial fortunes might leave the child unattended even to minimal, emotional or physical needs."

A. Yes.



Q. Further, "Confusion results from this oscillation between overindulgence and deprivation."

A. Yes.

Q. So, especially in the course or other unstable situation we come across cases where the parents can't really be depended upon to look after the best interests of their children.

A. Right, because they are in a stressed state themselves for that period of time, yes.

Q. And you might have situations, might you not, where the children's symptomatic behavior is a result, not simply of the child's own internal problems, but a result of the turmoil in (53) the family?

A. Yes. They have a reactive response to the situation.

Q. In fact, the story you told about that boy who got into trouble just, I think you said in the past week or two, his situation was one in which you testified that his father and his mother wouldn't step in to help him get hospitalized.

A. Well, they accepted the hospitalization. They wanted him to be hospitalized. They didn't do the extra little step which would have safeguarded him.

Q. Which would have kept him from getting arrested?

A. Right.

Q. It's true, isn't it, that in this divorce or unstable situation that the parents—well, let me quote from your article and you can tell me if you still agree with it:

> "Parents may interpret the child's behavior as retaliation due to their own feelings of guilt about having broken up the child's 'happy?' home, but the child usually is not deliberately revengeful and his

responses need to be viewed in the context of feeling hurt, frightened and angry about the loss and his need to let the parents know about this."

Do you still agree with that statement?

A. Yes.

Q. So that there may be situations where psychiatrists or institutions are confronted by parents who might simply give (54) their view of the behavior of the child without explaining the possibly, embarrassing marital situation and where psychiatrists might, in an unwarranted way, side with the parent before they can find out the actual picture?

A. Well, no.

I would have to qualify that statement in terms of a psychiatrist's job. It is to assess a child's functioning and what is going on with him emotionally, not just on the basis of the parent's complaints, but on the basis of evaluating the child and getting the child's story about what he feels and what has been going on and assessing his mental status and then coming to some diagnostic appraisal.

Q. And that assessment also involves assessment of the facts?

A. It involves an assessment of the facts; involves an assessment of what the parents are really saying as well as what the child is really saying. Hopefully, this gets to a more accurate appraisal diagnostically.

Q. Can you tell me what, in your opinion, or by your training gives you the extraordinary qualifications to decide what facts are true as opposed to the mental status?

A. I am afraid I don't understand what you just said.

Q. Well, in evaluating—



A. Since nobody claimed extraordinary kinds of powers which you are imputing—

Q. Well, have you ever participated, Dr. Sugar, in the (55) commitment of an adult?

A. Yes.

Q. Have you ever been in court during a judicial procedure for the commitment of an adult?

A. Yes.

Q. Have you ever testified in that kind of proceeding?

A. Yes.

Q. Now, at that proceeding you heard testimony, didn't you, from possibly conflicting sources about what kinds of behavior the person engaged in; isn't that right?

A. (No response.)

Q. You have to say "Yes" or "No" so the court reporter can hear you.

A. Yes.

Q. And in your psychiatric practice you also hear conflicting versions of the facts; isn't that right?

A. Right.

Q. Now, in that judicial proceeding for the commitment of an adult, it is true, isn't it, that it is the Court that decides on the conflicting facts?

A. Yes. That is what the commitment is about and is based on the evidence.

Q. It is based on the evidence?

A. Of the diagnostic appraisal.

Q. And the conflicting facts?

(56) A. And the complaints.

Q. Now, can you explain the reason that the commitment shouldn't also be about the same thing for juveniles? Why shouldn't there be a situation where the con-

flicting facts are given to the Court and the diagnostic appraisal of the psychiatrist is given to the Court and then the Court decides what needs to be done?

A. Why shouldn't there be commitment?

MR. ROTH: Objection on the basis—are you dealing with the same thing that we have been discussing before in terms of a judicial proceeding prior to commitment?

MR. FERLEGER: The question speaks for itself.

MR. ROTH: In order for Dr. Sugar to be perfectly clear on exactly what he is being asked, one of the things you are seeking is a judicial hearing prior to commitment. We don't want to mislead the doctor in not thinking that that is not exactly what you are asking, if that is what you are asking of him.

MR. FERLEGER: I asked the question and the doctor can answer the question.

MR. ROTH: But the question is not clear in my mind in the sense of your saying that evidence should be presented to the Court prior to commitment in order for the Court to make a decision; is that correct?

MR. FERLEGER: You spoke, Mr. Roth, before the (57) doctor had a chance to explain whether the question was clear in his mind.

THE WITNESS: I said it wasn't when I asked to have it repeated.

MR. FERLEGER: (To the reporter) Would you read the question back?



(Whereupon the pending question was read back by the court reporter.)

BY MR. FERLEGER:

Q. Did you hear the court reporter read back the question?

A. Yes.

I still don't understand what your point is.

Q. What is the reason for the juvenile who can't have the same procedure that you just described having been a participant in whereby the conflicting evidence is presented to the Court and the medical diagnosis is presented to the Court and then, as you have testified, the Court makes the decision about what needs to be done in a non-emergency situation?

A. Well, with the adult there is usually no one in loco parentis, except the Courts, and the law, and this is supposedly there to protect and safeguard the individual as well as society.

With the child you have the safeguard by parents, and since both parents function fairly suitably in that role, they are not going to want to incarcerate a child unless there is some specific need for it based on somebody's evaluating it (58) and having it then taken care of professionally; but if the procedure that you are suggesting be done, then I would see perhaps a nice increase statistically. I don't mean nice in terms of benefit. There would be quite a considerable increase, I would think, in terms of more crimes and more violence and more suicides and more other violent acts. There would be longer waiting lists to see psychiatrists, and it would be quite deleterious to the youngsters.

Q. Because you mean it is easier to get youngsters into treatment under a non-judicial procedure?

A. I am pointing out that there would be less delay in getting them help since the parents are assessing the child's needs rather than having someone evaluate and then somebody start some treatment procedures.

Q. When you talk about longer waiting lists and more crimes and all that sort of thing, under a judicial procedure, are you saying that judges are less likely—that the judges are likely to commit a smaller percentage of people than doctors would commit?

A. I am not talking about the percentages of commitments. I am talking about the delay in doing something needed for the child.

Q. But you have that delay, don't you, with adults as well and adults are capable of committing as serious crimes and disturbing behavior as juveniles, correct?

(59) A. Usually, in that case if a child—if the adult is in some way causing difficulties he is usually under the protection of the law.

Q. What do you mean "protection of the law"?

A. Well, he is usually safeguarded by the police, isn't he, or some other situation, or he is under a peace bond by the family to keep him in some kind of state where he is looked at.

Q. It is your information that there is no such procedures available for juveniles?

A. My point is not that there is no such procedure. My point is that you are impeding the pursuit of treatment and the delay would lead to more difficulties if the institutionalization isn't done when it is needed.

Q. But your testimony is for adults the way we get around that problem is by having peace bonds and other protections of the law?



A. You can put an adult in jail if you need to. Where would you put a child?

Q. In a juvenile institution.

A. There is a question of how suitable it is for the job.

Q. Isn't there a question as to the psychiatric institution for children?

A. Yes. It is a different sort of evaluation and a different sort of structure.

Q. Isn't there a question of how suitable jails are for (60) mentally ill adults?

A. Yes.

Q. So then, what are the alternatives for the adults? There is a delay for children and there is a delay for adults, isn't there, and they are both not very good for a psychotic's mental health?

A. Part of the delay with the adults is that society, I gather, is acting in loco parentis. Someone is taking the responsibility to do something to look after this person's interest whereas the child, the parents are looking after the incompletely, undeveloped person and his needs and they are looking after him.

Q. But you testified earlier for the child—it can be the police or the school or some other person besides the parents.

A. Yes, who first notices the behavior and brings it to someone's attention.

Q. Who looks after the interest of the child?

A. In loco parentis, if it isn't an emergency situation—

Q. Well, in the non-emergency situation—I still don't understand why we don't have the same problems for adults. We have the delay. We have the jails that you

testified are not very good for mentally ill adult problems.

Why should we have judicial procedures before an adult commitment?

MR. ROTH: I object on the basis that the question now is becoming argumentative and the doctor has responded (61) several times to it in connection with the development of the adolescent, et cetera, et cetera.

I think he responded at least three or four times, which the record will reveal.

BY MR. FERLEGER:

Q. In terms of the adult, do you feel psychiatrically that there is a need for a prior, judicial hearing before a commitment?

A. I presume I was here to discuss adolescents.

Q. And also differences between adolescents and children.

A. And their needs which, I think, I have answered.

Q. Can you answer my question? If you feel unable to answer, you can state that, but can you explain to me whether or not psychiatrically there is a need for judicial hearings before commitment of adults?

MR. ROTH: Is that before the voluntary admission by an adult of himself or before an involuntary commitment?

MR. FERLEGER: For an involuntary commitment.

THE WITNESS: If the person objects to being in there, whether he is delusional or not, if he calls counsel to look after that interest of his, then for



the sake of the law and the patient's understanding that he is in need of being there, not just because of psychiatric testimony, then this supports his need to be in the institution.

BY MR. FERLEGER:

Q. Dr. Sugar, isn't it true that a judicial proceeding can (62) also be traumatic for a juvenile delinquent who is in Juvenile Court?

A. Yes.

Q. And it is true that a proceeding which is a judicial proceeding can be traumatic for an adult as well?

A. Yes.

Q. An adult mentally ill or not mentally ill?

A. Yes.

Q. Lots of people get anxious and upset before appearing in court even for a traffic violation.

A. Yes.

Q. Now, you testified that you are familiar with the Gault Decision which requires hearings for juveniles in Juvenile Court when that procedure is for their rehabilitation.

Can you explain why the trauma of that hearing for that juvenile delinquent isn't enough to make it, in your psychiatric opinion, inadvisable to have a hearing?

A. At that point we have to establish if there is a psychiatric condition which needs immediate attention.

Q. Assuming we have one of those juveniles who is a juvenile delinquent or at least an accused one who has, as you testified many of them do, an emotional problem—

A. Yes.

Q. —would you, in that case, if a judge called you up, would you advise the judge not to have a hearing because it (63) might be too traumatic for the kid?

A. Not without my evaluating. I couldn't make that statement.

Q. If you had evaluated?

A. If I had evaluated him and I had come to that conclusion, yes, I would tell the judge what I thought, and if that was my opinion, I would render it.

Q. So you can conceive of a situation where it would be your medical opinion that the best interest of a possibly, emotional, disturbed juvenile delinquent where his best interests would not be served by having a hearing; is that right?

A. Right.

Q. Now, Dr. Sugar, you testified that commitment is sometimes appropriate for a number of classes of juveniles, and one of the situations you described in these words was "Some people don't fit into the family scheme."

Now, can you explain exactly what you mean by that?

A. Yes.

I was referring to someone who is psychotic and bizarre in their behavior and having delusions, persecutions, and they feel that everybody in the family is poisoning them or out to hurt them or people—or people in the family trying to accommodate to that. They have further accusations and threats made against them, and they are under constant strain because they feel the person is going to follow through on some of the threats they have made and in response to what they feel (64) are all sorts of perfidious deeds.

Q. For juveniles who have less serious problems, isn't it true that there may be situations where foster care or temporary care with a relative or some group, home-type situation where some treatment, alternative or living alternative—or some institutionalization might be appropriate?



A. Yes, that is sort of a form of institutionalization.

You are removing them away from the home which is sometimes treatment in and of itself. You are putting them in a foster care situation which sometimes is very useful treatment.

Q. In your opinion, should that decision be made by the Court or by a psychiatrist or by both?

A. I think it should be a psychiatrist's opinion in terms of the youngster's emotional needs and in terms of what this might potentially benefit him with by placing him in that kind of an institutional setting.

Q. Now, when a parent neglects a child or doesn't give the child enough to eat or, you know, someway is in a gross way not responsive to the needs of the child, and the child needs that kind of alternative placement, is it your opinion that that decision should be made by a Court or by a psychiatrist or by both?

A. Well, in that kind of situation, we are not talking necessarily of a psychiatric condition. We are talking about ordinary needs not being met, and the law or the family doctor (65) should be the responsible one for that.

Q. The law or—

A. We are not talking about a psychiatric condition there.

Q. That's right.

Who should make the decision?

A. Well, it is a legal question ultimately. It is obviously a legal question.

The doctor can initiate this, which is, for instance, what happens with child abuse cases.

Q. So your standard seems to be then when it is a medical or psychiatric question that the Courts shouldn't be involved?

A. No.

Q. But when it is a legal problem—

A. If it is a legal problem the Court should be involved to implement what is necessary for the law to implement and what is needed for the youngster just as I said in the child abuse cases. The pediatricians are the first ones to make the diagnosis and to bring attention to this. They are the ones that call the law. The law follows through on the diagnosis and places the child elsewhere for its own protection.

I am really not saying what you just intimated. I was saying that they can work harmoniously together, just as I mentioned.

Q. Now, in the case of a child who is, let's say, five years old, six years old, seven years old, do you feel that a child of (66) that age is mature enough to decide whether or not he or she wants to be institutionalized?

A. No.

Q. Now, in a situation where a parent might feel and perhaps a psychiatrist might feel that institutionalization is appropriate do you feel that the decision of the parent and the psychiatrists ought to be enough to effect institutionalization without the Court's interference?

A. Yes.

Q. You don't feel that there is any necessity for someone to be appointed to represent the interest of the child separate from the parents?

A. No.

What you are suggesting, if that is done, is that there is no need for the medical profession; that the medical profession's diagnosis and recommendations are not of any value.



Q. Well, it's true, isn't it, that just as when we have a hearing in this case, we will have experts, medical experts on both sides say that if someone who is interested in representing the child's interest separate from the parent's chosen psychiatrists, that we could have medical opinions on the other side of the point?

A. You may.

Q. And when there is that conflicting medical opinion, who do you think should make the decision?

(67) A. Well, I feel in many cases the conflicting medical opinion is either resolved by the parents, if it is a legal case, and if it is the responsibility of the judge, then the judge takes that into consideration.

Q. Well, this whole suit is about whether it should be a legal case.

If we have a situation where we have conflicting medical opinions about whether a five-year old ought to be institutionalized, is it your opinion that the parents ought to make that choice or that a Court ought to make that choice?

A. Why would it be a court case in the first place at age five?

Q. That is what the lawsuit is all about.

The plaintiffs' position is that the parents shouldn't be allowed to make that decision without it being a court case.

The defendants' opinion is that it should be.

You are the expert, and I want to know what your opinion is.

A. My opinion has been—

Q. That it should not be a court case; is that right?

A. Unless there is reason for it to be a court case.

Like, a criminal action or something that brings it—

Q. Without a criminal action when the child—

(68) A. I don't see the need for a court case.

Q. You think that the parents should be the ones to make that decision?

A. The parents are the ones who bring the complaint. The doctors are the ones you bring the child to.

Whether he is five or 15, the doctor is the one that makes the assessment.

Q. And the parents should be the ones to make the decision about institutionalization?

A. The doctor makes the decision. The parents follow through.

Q. If there is conflicting—

A. Then they can get a third person.

Q. And if there are ten opinions—

A. Then it is their ultimate choice, unless there is a legal condition such as a criminal act.

Q. If it is the parents' ultimate choice, what do we do in a situation in which you have testified to, where the parents have their own problems and are not in a position to make that choice?

A. Well, fortunately, those don't happen that frequently.

Q. When they do happen, we could have a situation where the parents are making a choice and it is not in the best interest of the child, couldn't we?

A. Well, if the child is in an institution, we presume that the people there are trained physicians; trained to do the proper (69) job, and that the child, if he doesn't belong there, they will do something appropriate about that. Otherwise, we get in a position ultimately according to what you are suggesting of having it like in Russia where the judges decide for political reasons that someone has a psychiatric condition.



Q. I don't understand why my five-year old suddenly is a political prisoner.

A. I am just extending your argument; that the doctors and the parents don't have the responsibility, and the State has the ultimate choice about matters that ordinarily are parental responsibilities.

Q. You did testify on direct examination, Doctor, that the dumping into mental institutions which Chief Justice Burger is concerned about has happened and the parents do abuse children.

A. It does happen, unfortunately, yes.

Q. And very often that happens with the cooperation of the psychiatrist; isn't that right?

A. It may be happening, but I think that the frequency of this happening—I would think that has been overstated by your comment.

Q. By what?

A. It has been overstated by your comments.

Q. Now, I would like you to explain, Doctor, your comment earlier when you testified, and I think these are your words, "That the point of having a hearing is mixed up with (70) sentimentality."

A. Well, yes.

You are saying that a five-year old should have the right to say I want a hearing.

Q. No, I am not saying that.

A. That was the case you were just talking about hypothetically, about the five-year old.

Q. I asked you whether or not a child had the maturity—

A. No, he doesn't.

Q. —to ask for a hearing.

A. No.

Q. I did not state my opinion on that.

Can you please explain your comment that the point of having a hearing for children 18 and under—that is the age range we are talking about which is mixed up with sentimentality.

A. You are assuming that an 18-year old, in spite of the points of developmental situations being incomplete, has the capacity to completely understand his condition when he is emotionally ill, needing hospitalization or when he is retarded intellectually and has an I.Q. of 50, and you are assuming, according to that, that the parents have no intelligence and no adult development, although apparently, they must have to arrive at that point in life.

Q. That is your definition of sentimentality to you?

A. I am not giving you my definition. I am pointing out that (71) there is an erroneous assumption that doesn't jibe with the facts; that the child's development, according to what is being proposed is complete. We know it is not. This also indicates that there is a question about the parents' abilities and responsibilities which is always deficient, which it is not.

Q. Well, can you answer my question now? You said the point of having a hearing is mixed up with sentimentality. Can you explain?

A. Yes. I am saying that everybody, according to this notion, is being put into a procrustean bed rather than a bed used for their development, their state of needs and the diagnosis.

The idea of everyone having a judicial hearing—it might be very nice, but it is really, I think, unnecessary in the vast majority of the situations.

Q. Well, that is also true, isn't it, for the various capabilities and intellectual and emotional levels of adults



as well? Don't we have the same procrustean bed where adults might be mere psychotic or might have absolutely no insight into their condition where all these adults are being given by the law? Don't we have the same psychiatric problem there?

A. I don't understand what you are saying.

What you correlate—since I said the parents take the responsibility; since their incomplete development is still their responsibility—

Q. But the law does not allow the parents of a 20 or 30-year (72) old child to take the responsibility when that 20 or 30-year old child is not able to take care of himself or herself?

A. I am afraid I don't know what you are asking.

Q. When you have a situation where a 25-year old woman is behaving in a bizarre way, let's assume she is living at home with her parents; where this adult woman is acting in a way which may be detrimental to her; where she may have absolutely no insight into what a psychiatrist would call her need for treatment, do you feel that her parents, acting in loco parentis ought to be allowed to decide on commitment?

A. Yes. That is just like for any adult. You have loco parentis in lieu of society at-large. Someone takes the responsibility. Someone like the policeman on the corner takes the responsibility.

You see someone doing something bizarre. He has his duty to perform of taking that person off the street for their protection and for society's protection.

Q. So those parents of the 20 or 30-year old, you feel they ought to be in the representation of society and it is your duty to be able to institutionalize their child?

A. In the usual procedure of having someone evaluate and assess what is going on, which is what is done—

Q. With or without a Court making the decision?

A. If the person agrees to it, then there wouldn't be a need.

Q. If the person has no insight at all?

(73) A. If the person has no insight and has a delusion that they're being persecuted and they want to have a lawyer come in and the lawyer says "You don't have a persecution complex; you are not psychotic and I will defend you in court—"

Q. Suppose there is no delusion of persecution. Suppose that the parents feel the child needs psychiatric help.

A. Yes.

Q. Suppose they invite a psychiatrist to come over for tea and the psychiatrist makes an evaluation and agrees, do you feel that the Court should be involved or should that psychiatrist's evaluation be sufficient?

A. The psychiatrist's evaluation should be sufficient.

Q. Dr. Sugar, how many articles which you have written have been published?

A. Approximately 35.

Q. How many of those articles deal with children?

A. I don't know.

Q. Do you have a list of your articles with you?

A. No.

Q. Do any of those articles deal with the law and psychiatry?

A. No.

Q. Have you had occasion to study questions involved in forensic psychiatry?



A. Not specifically in great depth. I have studied some.

Q. Just to clarify one further thing: When you stated earlier (74) "Due process is available in due time," you were not purporting to give us your legal opinion about what due process is, were you?

A. I was quoting what I heard here in terms of the law, allowing a hearing to be held in a certain number of days after institutionalization if the person chose to institute themselves.

Q. Now, suppose we have that hearing which is held after institutionalization and suppose the Court at that time finds that institutionalization is not proper and was not necessary; isn't it correct that that uninstituted institutionalization could have a bad or detrimental, psychological effect on a child?

A. Yes, it could have an upsetting effect.

Q. Now, Dr. Sugar, there is a law pending in the Pennsylvania Legislature which would change the age at which children could voluntarily admit themselves from 18 to 14. It would thus allow children between 14 and 18 to go in and out of mental hospitals of their own volition, and it would require parents to go to court prior to any commitment for 14, 15, 16, 17 or 18-year olds.

Based on your testimony here today, I would understand that you would be opposed to that kind of statute; is that right?

A. I don't understand what you are saying about the parents going to court.

Q. The law would require that only children under 14—the parents—strike that.

(75) For children 14 and over, for any kind of involuntary commitment, there would have to be a court procedure.

From your testimony about the problems of adolescence, I would understand that you would be opposed to that kind of statute?

MR. ROTH: It is not a law.

THE WITNESS: It is a current proposal?

MR. ROTH: It is a current proposal.

THE WITNESS: Well, I would like to see the law in its details before I could answer that appropriately.

BY MR. FERLEGER:

Q. Well, based on what I said—

A. Based on what you said, I would think that if a youngster says to a professional "I am upset, disturbed," et cetera, "I want to be hospitalized," and he presents himself at a psychiatric institution, he would not be admitted until he has been assessed.

Q. I understand that.

A. So then if he had been admitted and does need help, I would assume that they could keep him there since he wants to be admitted and he has a condition that needs attention medically, and the parents could be contacted then. Hopefully, they would agree with this.

Q. Now, where the child does not want to be institutionalized under this proposal that we are discussing, the parents would have to go to court for children 14, 15, 16, 17 and 18.

(76) Now, I understand that you would oppose such a procedure; is that right?

A. That's the thing that we are discussing here.

Q. Right.

A. Yes.



Q. Dr. Sugar, you testified earlier that you are being paid for your testimony here today. How much are you being paid?

A. $60 per hour.

Q. Does that include any preparation time?

A. Yes.

Q. How many hours have you spent in preparation?

A. I have not totaled it yet.

Q. Approximately?

A. Approximately two or three hours.

Q. Dr. Sugar, you testified that institutionalization can sometimes provide a comfort to the child, although the child may say he hates it. Are you familiar with any mental institutions in which a feeling of hatred or discomfort at the conditions there would be appropriate?

A. Yes. There have been a number of those described wherein some of the conditions were lax and there was some difficulty in maintaining some of the things required for the patient.

Q. So, if a child objected to being in an institution like that, there would be cases in which you would agree that the child's objection is correct?

(77) A. Yes; that he should be transferred to another suitable place.

Q. Now, Dr. Sugar, I have been told numerous times by psychiatrists that it is very difficult and sometimes impossible to treat patients who don't wish to be treated; that therapeutic results can be substantially improved through the use of—they can be substantially improved when the patient is voluntary and agreeable rather than involuntary and disagreeable; is that correct?

A. That holds for out-patient care, but for the in-patient, it is a different situation because they can be tak-

ing medication, which the staff can see to it that they get, whereas on an out-patient basis, there isn't that kind of control, and if there isn't cooperation from the patient, then the therapeutic effect may come to less than optimum.

Q. Isn't it correct that the medication which in-patients get helps get the patient to the point where other forms of treatment, you know, towards a possible cure or alleviation can begin? Isn't it true that the drugs are not, you know, any sort of cure—

A. Well, they have helped substantially, and many patients when admitted to the hospital are given doses of tranquillizers and they might get shock treatments, and in spite of the treatment—he might get over a great psychotic depression and get over it quite well despite their objection. They do get benefits and, many patients do get [illegible ] of tranquillizers on a graduated (78) basis so they may leave the hospital. They are functioning better at that time. They know the severity of their illness and they can go back into society.

Q. Take the situation where a patient objects to the shock treatments which you have just mentioned.

A. Yes.

Q. Do you believe it should be the doctor's decision as to whether or not—

A. Yes.

Q. And not the Court—

A. That's right.

Q. How about procedures of an amygdalotomy?

A. That's your term.

Q. Or a cinculotomy?

Should those procedures be done based on a decision by a doctor or by a Court?



A. I think we are getting into the surgical field, aren't we?

I would suggest that as of the present time those procedures are still not quite far enough down the road. They are still experimental.

Q. Shock treatment you feel is a proven efficacy.

A. Yes.

It is the same question you are asking me whether the Court should approve on a million units of penicillin to be given—

(79) Q. What?

A. You are asking me the same kind of question if the Court—if a luetic should be given one million units of penicillin.

Q. That was the comment with reference to shock treatment?

A. Yes.

Q. It is your position then that whether a patient is voluntary or involuntary and an in-patient that that distinction of voluntary versus involuntary doesn't matter in terms of the kind of treatment that can be done?

A. It is preferable if he is cooperative because then you have a cooperative part of the patient to deal with, and it is easier to get on with the work, but there is resistance that has to be dealt with in terms of the opposition to it, and then it has to be dealt with. That's part of the problem also.

Q. Is it part of the treatment for an involuntary—

A. To cooperate?

Q. To be incarcerated?

A. To want to cooperate in terms of his own treatment.

Q. And that would mean to cease objecting to being institutionalized?

A. Not necessarily to cease objecting. He may continue to object, but as long as he cooperates in his own treatment, in spite of the objections, under the circumstances, just like patients may gripe about going to see the psychiatrist in his office, but they still come and they still talk about their (80) conflicts. They still gripe.

Q. In that situation the patient has a choice not to come.

A. Yes; because his functioning is such that he can get along without being institutionalized.

Q. You testified that the people with emotional problems may have trouble deciding or may have conflicts about whether or not to institutionalize themselves; is that correct?

A. Yes.

Q. It is true for adolescents as well as for adults, isn't it?

A. Yes.

Q. Both adolescents and adults—for example, your evaluation of them may make the incorrect choice as to what is medically appropriate; isn't that correct?

A. Yes.

Q. And you understand, don't you, that in Pennsylvania for an adult who makes that incorrect choice, in a non-emergency situation, the only alternative would be a judicial hearing, while if it was a juvenile, the commitment could be made without a judicial hearing?

A. Yes.

Q. Now, Dr. Sugar, you testified that when some social control agency—you mentioned the family or the police or the school, does something to help a child with



some problems that the child may be having, that the kid very often feels a relief; is that right?

(81) A. Yes.

Q. Would you include the Court within those social agencies?

A. It may at times, yes.

Q. Now, let me give you a situation and ask your opinion on it.

Where a child is accused of doing certain things or exhibiting certain bizarre behavior, and the child has a chance to have a lawyer representing him or her, or the child has a chance to give the child's side of the story, and where an independent person, a judge, who the child hasn't met before and has no previous involvement in the case is the one to decide, don't you think that in a situation where the child is not agreed to treatment that the child will feel treated more fairly and have more of a sense of the justice of the situation than in the alternative of the situation where a parent and a doctor get together?

A. Not necessarily, no.

Q. Will you explain.

A. You are dealing with a hypothetical situation, and we don't know what the dynamics are. We don't know what led into the behavior used as a basis for the diagnosis and for admission.

We are talking generally about a point of representing someone's interest and not getting treatment. We are not talking about the need for treatment, the basis for the diagnosis, the basis for a medical opinion being rendered, so just because a lawyer or a judge then say you're really needing (82) admission after the judicial hearing, that doesn't mean that the youngster really is going to be more pleased about it than he was before. Some youngsters are

quite antagonistic to any authority. Some youngsters might be quite manipulative . They will do anything to avoid something that looks onto them as disfavor.

Just because the judge says it, that doesn't mean it will be agreeable or acceptable.

As we know, many of the involuntary admissions for adults, even though they have been adjudicated, the adults still object, still raise holy hell. They still want to get out.

That doesn't mean because the judge says it that a guy is going to be pleased about it.

Q. All right.

But in a situation where an adult has been committed by a Court and objects, the adult has the right to appeal in that situation?

A. We are talking about his accepting it.

I am pointing out that he may not accept it any more because a judge has said so than because his parent or because the doctor has said so.

Q. Do you think for the adults that there is not in general more of an acceptance in a situation where the law would allow commitment for any judicial hearing whatsoever?

A. I don't think there is any way I can answer that question. (83) I would say there is no way to make any kind of statement about that.

MR. FERLEGER: No further questions.

MR. ROTH: I have a few on redirect.

BY MR. ROTH:

Q. Doctor, in order to clarify what I consider to be misleading statements made by opposing counsel in connection with your examination, first of all, with regard to



the purpose of the lawsuit, you have been advised of the two sections that are in question, the voluntary commitment sections which address both juveniles and adults; is that not correct?

A. Yes.

Q. And have you not been advised that plaintiffs are seeking either to have juveniles treated similarly to adults in that juveniles will be allowed to admit or release themselves like adults, or, secondly, in the alternative, if that could not be afforded, that a juvenile would be given a judicial proceeding prior to commitment wherein an attorney would be representing the juvenile and explaining the condition of the juvenile to, if you will, question the validity of the psychiatric evaluation made by other psychiatrists and ultimately determining whether or not the child should be institutionalized? Is that not your understanding?

A. Yes.

Q. Okay.

(84) Now with regard to the procedure in Pennsylvania and the additional regulations, and I'm sure you have read the regulations, have you not?

A. Yes.

Q. Just in looking at the additional regulations which is Annex A, I don't think we need to introduce this as an exhibit. However, it is the additional regulation adopted by the Department of Public Welfare on September 1, 1973.

Could you just read that first paragraph on how juveniles are referred.

A. "All juveniles of aged 18 and younger, to be admitted to institutions must be referred from a recognized medical facility, mental health, mental retardation thera-

pist or mental health agency. However, mentally retarded juveniles may be referred by either a pediatrician or general physician or a psychologist."

Q. Doctor, in terms of a juvenile coming to the doorstep of an institution, it is not as if a parent brings a juvenile and says "Look, I want my child committed or admitted." However, he has to undergo numerous safeguards; is that not correct?

A. Yes.

Q. And then under the Act itself, which you are familiar with in terms of Section 402 and 403, it states, which I would request you to read, and we are referring to Section 402 of the Mental Health and Mental Retardation Act of 1966—would you read that, please.

(85) A. "When an application is made, the Director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he may be admitted."

Q. So, then we do have an additional psychiatric evaluation being done of the patient.

Now, according to your understanding, would you feel that those are appropriate safeguards?

A. Yes.

Q. Now, there has been—

MR. FERLEGER: I just want to note for the record that there is no indication in the regulations that the referring examination cannot be one and the same as the examination that is made under Section 402 (b).

MR. ROTH: Well, the only way you can get to the institution is by the referral or recognized medical facility.

Supreme Court, U. S.
FILED
JUN 18 1976
MICHAEL RODAK, JR., CLERK

**VOLUME II—Pages 435a-865a**

**APPENDIX**

# In the Supreme Court of the United States

**October Term, 1975**

**No. 75-1064**

JACK B. KREMENS, Individually and as Hospital Director of Haverford State Hospital; FRANK S. BEAL, Individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; WILLIAM B. BEACH, JR., Individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,

Appellants

v.

KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND; Minors, Through Their Next Friend, Individually and on Behalf of All Others Similarly Situated,

Appellees

*APPEAL FROM THE JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA*

**APPEAL DOCKETED JANUARY 27, 1976**
**JURISDICTION NOTED MARCH 22, 1976**

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MR. FERLEGER: There is no indication that the Director cannot then have the examination under 402 (b) or the examination done by the referring facility.

A. I would think that quite unlikely in view of the wording of this.

BY MR. ROTH:

Q. Doctor, Mr. Ferleger questioned you whether or not you have any objection to the Court working harmoniously with the psychiatrist, and then he sort of led you down the primrose path (86) of questioning whether or not facts should be presumed to the Court.

In essence, viewing the purpose of this lawsuit and knowing full well what is sought in the way of relief, I am questioning whether you feel that juveniles should be allowed to admit and release themselves at will as adults are?

A. No.

Q. And could you—I'm sorry if we have to be repetitive. We just have to clarify this.

Could you indicate why?

A. For the reasons of the incomplete emotional, intellectual, physical, hormonal things that the adolescent has not achieved yet and that he is under the care and responsibility of the parents, and the parents are the responsible parties. So, if a youngster feels so threatened, so disturbed that he feels he wants to be admitted and somehow he hasn't gotten the message across to his parents and he presents himself for admission at a psychiatric facility and the proper examination is done, and the diagnosis is made indicating he needs admission, then in that case the admission could be followed through with parental approval. If not, then approval of the law would be sought.

In other words, if a youngster needs to be admitted because he is a threat to himself and society and the parents say no, then the physician has a choice of contacting the law and saying make a judicial hearing to admit in spite of the (87) parents' objection.

Q. That goes along with the example before if a child wanted assistance and came to you, and even though the parents did not want to institutionalize the child, and even under our current safeguards, if you will, that would not likely happen in that there would be a referral to the institution, but nonetheless, assuming a child came to the institution and was begging for help and you, in your opinion, felt that the child needed help, although you may like to institutionalize a child at that point, you would be precluded from that, according to the law, correct?

A. Right.

Q. Now, however, that would not preclude you from seeking—from petitioning the Court?

A. Yes.

Q. In order to have the guardianship of the parents relieved?

A. Yes.

Q. With regard to the determination of adults and how they are admitted involuntarily into Pennsylvania and since we have not addressed ourselves to this section because, as you say, and we discussed, we were questioning your professional opinion in connection with juveniles and the treatment of juveniles and adults, Doctor, under Civil Court commitmments in Pennsylvania, and I state under Section 406 so you have a better understanding in terms of the questions that were asked of you before "Whenever a person is believed to be mentally disabled and in need of care (88) or treatment by reason of such mental



disability, an examination of such person has been made by a physician or physicians or for any reason the examination of such person shall not be made, a petition may be presented to the Court of Common Pleas of the county in which the person resides or is afforded a medical examination or commitment to an appropriate facility for examination, observation and diagnosis."

Then it goes on to say "By whom the petition can be made which may be a guardian, friend, individual standing in loco parentis or by an executive officer or authorized agent of a governmental or recognized non-profit health and welfare organization, or any responsible person."

Now, the petition sets forth the facts upon which the petitioner bases his belief of mental disability and the efforts made to secure an examination of the person by a physician. Then, the Court, upon consideration of the petition, issues a warrant requiring that the person be brought before the Court; fixes a date for the hearing and notifies the parties in interest.

After the hearing the Court can order an immediate examination by two physicians or order the commitment of the person believed to be mentally disabled. However, that commitment will not occur for longer than 10 days and there will be a report back to the Court and another hearing will be held.

Now, that is basically the way a Civil Court commitment occurs for an involuntary, committed adult in Pennsylvania.

(89) MR. FERLEGER: Is that a question?

BY MR. ROTH:

Q. And the question which I am leading up to is do you feel that juveniles who do not wish to be institutionalized ought to be afforded the same procedures as adults?

A. No.

You are viewing the issue that someone is taking the responsibility for him which is the parents, and you are abrogating their responsibility, and you are abrogating the considered opinion of psychiatrists who have made an assessment and a diagnosis and recommendation.

Q. Now, Doctor, in connection with a juvenile who does not want to be admitted to an institution and he is objecting, as the plaintiffs are saying, well, you may render an opinion saying that the child needed this institutionalization and some other doctor may say he does not, and there should be a finder of fact and that we should go to the Court then and have a judicial proceeding. How would you resolve that type of conflict?

A. I'm afraid I missed the first or the second part.

Q. If you feel that you have seen a child and the parents have explained the history, et cetera and you feel that the child warrants institutionalization—

A. Yes.

Q. —and the child is objecting and another psychiatrist evaluates the child, my question is whether or not the child (90) needs institutionalization at that point, what would you feel ought to be done at that point? Do you feel that it is necessary then to go before the Court as the plaintiffs would like to do, or do you feel that any other avenue could be resolved?

A. Well, there may be a different slant.

The second psychiatrist got from some bit of data that was admitted or that was not stressed or brought insignificantly in the first evaluation. So, if there is some kind of difference of opinion it might be useful for the two psychiatrists to come together to discuss what they feel and have a conference about it to see where they differ, or it



might be useful to have a third psychiatrist assess the two situations and evaluate the child and see what he thinks about it because there can be a difference of opinion. There are differences in theory and differences in approach in various situations.

So, if the parents are interested in handling the patient suitably they will have that further evaluation and check it out and have an opinion rendered that assesses all the possible facts.

Q. In other words, you feel that it can be handled by the psychiatrists?

A. Yes.

Psychiatrists can call for consultation or the parents can call for consultations of another person.

Q. Doctor, in connection with the harmonious working together (91) of the Court and psychiatrists, it is my understanding now that you feel the Court can come into play after the commitment. However, it is imperative that in order to preclude any delay of treatment of the juvenile, and it is based upon his chronological age which is imperative and indicative of his developmental state, et cetera, et cetera, that it is necessary to render treatment as quickly as possible; is that not correct?

A. Yes.

Q. And then if a judicial proceeding were to occur it would occur after admission; is that correct?

A. Yes.

Q. Assuming that children were allowed to admit and release themselves, would you find a lot of children who would engage in the use of drugs to be institutionalizing themselves on a Friday night late and then asking out early Saturday morning? Do you think that would occur?

A. Yes, unfortunately.

It might again be sort of a parody of utilizing the youngster to be his own physician instead of the physician making an assessment for which they are trained to do and do what is needed for the youngster because if he just admits himself and he says I want to go out tomorrow without an assessment, what has been accomplished?

Also where is the parents' responsibility? Are they being allowed responsibility for looking after the best interests (92) of their child since we assume in this society that the parents are interested in their children and look after their interests to the best of their ability?

If the youngster said "I want to go in the hospital tonight," it might be because he is afraid of coming home to see his parents which doesn't mean that he shouldn't be afraid. It means that the hospital may not be the place for him or the hospital might be the place for him. If it is, he should not be allowed to go out the next day and consider that what he went in there for 12 hours before is all suddenly vanished.

Q. Would you feel that juveniles whether admitted to State institutions or general hospitals, ought to be given hearings prior thereto if a child has, for example, an appendectomy to be performed and the parents want to place his child in a general hospital for the appendectomy, but the child refutes that? Do you think a hearing should be set up beforehand?

A. No.

Q. Why not?

A. Well, you might end up with a dead child or a child who has a ruptured gangrenous appendix or peritonitis instead of saving his life and avoiding the morbidity that peritonitis carries with it. You would have had the



whole thing dealt with properly in a couple of hours if the parent and the doctor were allowed to proceed, so that it would be to the child's interest and ultimate displeasure to have his wishes accepted since he (93) is not in a position to assess the fact that his pain in his abdomen is what it really is. He is not trained to assess it and he doesn't know the consequences, and the parents do have some idea about it, and the doctor makes a diagnosis saying surgery is indicated even though the youngster is frightened, which is the usual thing to be, and the usual thing is to object to it.

The needed course is what the recommendation should be in spite of the child's objection to it.

Q. Similarly then, juveniles would really be unaware of the degree of their emotional problem?

A. Just like adults, only more so.

Q. But there is enough of a distinction based on development and growth where an adult could make his own admission as is allowed by the law and released?

A. Yes, but it is still not on his own. It is still based on his feeling in his admission and psychiatrist's saying yes, you do have this condition. This diagnosis requires you to be in the hospital. This is still not the patient being his own doctor.

Q. Doctor, there has been some discussion about offspring of parents who suffer from severe emotional problems. Now, whether or not the parents have suffered or are suffering emotional problems, and based upon how a child becomes institutionalized in Pennsylvania, do you not feel that there is enough (94) of a review prior to the admission of any juvenile in order to determine whether the parent is using the child or whether or not the child actually needs institutionalization?

A. I think there is sufficient review and consideration of the total situation and proper safeguards by what the law currently has arranged.

MR. ROTH: I have no further questions.

BY MR. FERLEGER:

Q. Dr. Sugar, can you tell us what parts of the Pennsylvania Mental Health Law you became familiar with or read prior to this hearing?

A. These.

Q. All right.

Can you either indicate what they are or hand them to me, and I will indicate for the record. The papers you are holding—

MR. ROTH: Will you ask which portions of it you have?

BY MR. FERLEGER:

Q. I see you are holding the entire Mental Health Act.

Did you read the entire thing?

A. Yes, I looked through it.

Q. What other legal documents in preparation for this deposition did you read?

A. Exhibit A.

(95) Q. There are no such exhibits in the record.

A. Whatever these are.

Q. If you could either—

A. I don't know what you call these.

Q. Well, I can't see what you are talking about.

MR. ROTH: He read the results of the State Hospital Analysis.



MR. FERLEGER: I don't know what you are talking about.

MR. ROTH: The Summary Sheets.

MR. FERLEGER: The Summary Sheets to the interrogatories which were submitted to the Court in this case?

MR. ROTH: Right.

MR. FERLEGER: Okay.

MR. ROTH: This was about the new law lowering the age from 21 to 18.

MR. FERLEGER: Which was attached to an exhibit, I believe, Exhibit A.

MR. ROTH: To a Memorandum of Law which was also reviewed by him to your Complaint. This was to my answer to your Complaint, a Memorandum of Law of Sovereign immunity which was sent. This was in answer to interrogatories of the Court Order.

The additional regulations and our most recent Memorandum of Law—

(96) The last thing you referred to, the Memorandum of Law with regard—

MR. FERLEGER: That is—is it filed of record in this case?

MR. ROTH: Yes.

MR. FERLEGER: Well, the last memorandum you referred to, can you tell me what that is or let me see it instead of keeping it away from me?

MR. ROTH: Mr. Ferleger, I object to your obnoxious attitude, but I will be more than happy to give them to you.

MR. FERLEGER: May I see it?

MR. ROTH: It is a Memorandum of Law that was filed—we are trying to find a date on it. I think this may have been one of the first ones filed.

MR. FERLEGER: May I see it?

MR. ROTH: Yes.

BY MR. FERLEGER:

Q. So you have not seen any of the Memoranda of Law of the plaintiffs expressing their position; is that correct?

A. Just what I have seen.

Q. You have not seen anything with my signature at the end giving our opinion on the merits of the lawsuit, have you?

MR. ROTH: Just the Complaint.

THE WITNESS: This is what I have seen.

(97) BY MR. FERLEGER:

Q. Do you recall reading any memoranda or briefs with my signature at the end expressing our position of the plaintiffs on the merits?

A. I will look through it and see.

MR. ROTH: I object to this whole line of questioning in that it is irrelevant.

BY MR. FERLEGER:

Q. Is that also your answer, Dr. Sugar?

A. Yes.



Q. Dr. Sugar, you testified just now to Mr. Roth that juveniles shouldn't be allowed to admit and release themselves to institutions. What ages were you talking about when you used the word "juveniles" in that context?

A. The specification here being under 18.

Q. Do you believe that 19-year old adolescents ought to be allowed to admit and release themselves?

A. They are treated as adults. They have the majority. That is the law.

Q. I am not talking about the law. I am talking about their mental condition.

A. Yes. They are in a much more mature condition.

Q. Much more than the 18-year olds?

A. Yes.

Q. So, it is your psychiatric opinion that 19-year olds (98) ought to be allowed to admit and release themselves?

A. From a psychiatric evaluation.

Q. So your answer is yes?

A. It is not yes. It should be on the basis of a psychiatric evaluation.

Q. And it is your psychiatric opinion that with psychiatric evaluations 18-year olds should not be allowed to admit and release themselves?

A. Yes.

Q. I thought, Dr. Sugar, that you had testified earlier that adolescents, 15, 16, 17 or 18 ought to be allowed to admit themselves with a psychiatrist's evaluation.

A. Yes, I did. Excuse me. I had a lapse in what you were saying.

Q. What is your opinion then? Should they or shouldn't they?

A. They should be allowed to admit themselves if the psychiatrist agrees that they need admission.

Q. So then what you testified to Mr. Roth then was incorrect?

A. I testified to the same thing.

Q. Well, I believe the record will show that you testified that they should not be allowed to admit or release themselves.

A. I said they would be allowed to release themselves. I said if they need to be admitted and they present themselves at a facility and they say "I am disturbed, I want help," and the psychiatrist concurs in making the diagnosis and he suggests (99) an admission would be the best course, then they should contact the parents and then the procedures should be arranged for the youngster to be admitted.

The youngster has a right to say "I hurt," and then somebody responds. So, the psychiatrist, if he is the first one, he makes a diagnosis and then he contacts the parents or guardians and they take—

Q. Suppose the parents don't agree?

A. I took up that point earlier with Mr. Roth.

Q. What is the answer if they don't agree?

A. The physician has the choice then of contacting the law to institute proper proceedings; to admit this youngster because he is a danger to himself or others.

Q. In terms of your expert opinion on what the law should provide, the law now provides that people above the age of 18 may make applications to mental institutions. Do you feel that children between the ages of 13 and 18 ought to be allowed to make that application understanding that after the application there will be an examination?



A. I think I just answered that question.

Q. Do you feel that they should be allowed to make that application?

A. I think I just answered that question.

Q. Can you answer my question?

MR. ROTH: I object.

(100) BY MR. FERLEGER:

Q. Do you feel that children between the ages of 13 and 18 should be allowed to make application to an institution?

A. By "application," what do you mean?

Q. Under the statute that you are familiar with.

A. I want to know exactly what you are referring to when you say "make application".

I just answered the question of the youngster if he is disturbed and he presents himself at an institution or a psychiatrist's office and says "I am upset. I want to be in the hospital."

Then the psychiatrist may make an evaluation and then follow the procedure I just mentioned.

Does that answer your question?

MR. ROTH: I object to this on the basis that Dr. Sugar has already replied to the Act and indicated that parents admit their juveniles up until 18 and has indicated when you tried to question and indicate whether or not he was saying juveniles should be able to apply for admission. Dr. Sugar responded to that by saying no, that juveniles, if they need help, can seek help, but the application still goes through the parents.

I can't understand why you are harassing him with this question four or five times.

MR. FERLEGER: He has testified in both directions (101) on this question.

MR. ROTH: He has not.

MR. FERLEGER: He said himself that he misspoke.

We are talking about the word "application".

THE WITNESS: Does that clarify the fact that I do not understand what your question was and that, therefore, I corrected it?

BY MR. FERLEGER:

Q. Dr. Sugar, we are talking about Section 402 of the Mental Health Act.

The word "application" is used in that section. That section states: "Application for voluntary admission to a facility for examination, treatment and care may be made by (1) any person over 18 years of age."

For people under 18, we understand the provisions are the parents or the guardian and that they have to make the application.

MR. ROTH: Or individuals standing in loco parentis.

BY MR. FERLEGER:

Q. After the application then comes the examination.

My question is, and this has not been asked before at all: Is it your expert opinion that that application should not be allowed to be made by a person between 13 and 18 or should the person between 13 and18 be allowed to make that application?

(102) A. What does "application" cover?



Q. Application is a request to the institution to admit and/or examine.

A. I just said that he could make application.

Q. The reason—

A. Excuse me. I am going to have to be getting back. I would like to have some idea of where we are in terms of completing.

Q. I probably have another 20 minutes or so.

The reason that I wanted to clarify that is because the Complaint that you have read, that the plaintiffs have filed, are asking that people below the age of 18 ought to be permitted to make that application.

A. Well, if it is in the law already, how can there be a complaint?

Q. It is not in the law, and the law states that people below the age of 18 cannot make an application.

A. I see.

Q. You have testified for some people below the age of 18 that they ought to be allowed.

A. Okay.

Q. Now, Dr. Sugar, in the past year or so can you tell us how many occasions you participated in a judicial proceeding for a mental health commitment?

A. In the past year?

Q. Yes.

(103) A. I really don't know offhand.

Q. Can you estimate?

A. Very few.

Q. More than five?

A. No.

Q. In the past five years, what has been your average number?

A. I do very little hospital work. I have participated in this very little in the last few years.

Q. When was the last time, if ever, that you worked as an institutional psychiatrist?

A. I have worked in institutions and I have been a consultant to a variety of institutions, and I still am.

Q. When you state "I do very little hospital work," what do you mean by that?

A. By that I mean direct, primary care being the responsible physician for the immediate day-to-day care of the individual.

Q. When was the last time, if ever, that you had responsibility for direct, primary care in an in-patient facility?

A. Yesterday. The day before yesterday.

Q. How many days of the past year have you been involved in that?

A. Perhaps a week.

Q. So it is correct that your main experience does not involve such?

(104) A. My main recent experience involves office practice rather than hospital practice.

Q. When was the last time that your major responsibilities involved hospital practice?

A. I just told you, the day before yesterday.

Q. Has there been a period of time during which you have been involved as a hospital physician rather than an office physician?

A. I think that I'd better clarify what I am saying.

In my private practice—I at one time did a good deal of hospital work as well as office psychiatry.

In recent years I have not been doing very much hospital psychiatry. In other words, I treat my patients in



the office. If they are manageable for treatment, I treat them in the office. If not, then I refer them to someone else.

Q. You said "at one time". How long ago was that?

A. Oh, some eight years ago, I guess. Maybe 10 years ago.

Q. Now, Doctor, you testified at the end of a long question from Mr. Roth during which you read Section 406 of the Act, and you felt that those procedures would be bad for children. Those procedures required notice and a hearing and counsel and all that. Is that your opinion, Doctor?

A. If I rendered it a few minutes ago, I think that states the facts for something.

Q. And the reasons that procedure would be bad includes the trauma of a judicial proceeding and the other factors that (105) you mentioned earlier?

A. I stated my reasons earlier.

Q. Now, can you explain why those procedures should occur under the regulations which Mr. Roth referred to because those regulations, you know, require that when a juvenile objects that all these 406 procedures that you just testified are bad be followed through.

A. He was already under care of a psychiatrist and in the hospital. He is in an institution where some controls are offered and treatment is going on. He is in a safeguarded situation of a medical facility to look after him. So, when he is having a hearing, that isn't in that kind of context.

Q. The hearing in court would be before a judicial officer?

A. But he is essentially in a hospital and—the hearing may sometimes be held in the hospital.

Q. So the difference is that the juvenile is already in the hospital and at that point you feel that the Section 406 procedures are okay or at least not objectionable?

A. He is getting treatment. He has had the recommendations of admission and treatment and already started on that.

Q. How long does that usually take, those recommendations and decisions to begin treating? How long after institutionalization?

A. Well, once he is in the hospital that is part of the treatment.

(106) Removal from the home—removal from the home for any adolescent is treatment in and of itself. It takes him away from some pressures at times that they have within the family or within their neighborhood or wherever the problem may be.

Q. But hospitals also offer individualized treatment; is that correct?

A. Yes.

Q. How long after institutionalization would they typically begin?

A. I am pointing out the treatment is already under way when the individual is in the hospital.

Q. But I am talking about the additional individualized treatment.

A. I have no figure to provide for that.

Q. Usually it takes more than a couple of days, doesn't it?

A. It may be the same evening. It may be the next morning. There is no usual kind of figure that I can provide you with.



Q. Now, Doctor, you testified about this revolving door idea that if juveniles could institutionalize themselves they could sort of go in and then request to leave and then if they got out could come right back in again.

I want to check whether or not that it is still your opinion because you have now testified that juveniles should be allowed to apply for institutionalization on their own. (107) If juveniles would be, as you wish them to be, allowed to apply for their own institutionalization, would we still have this problem with them going in and out?

A. I think I clarified that point in my earlier testimony that if they do apply, they are admitted. Then they should be admitted to stay for as long as the psychiatrist needs them there.

Q. But the Pennsylvania Mental Health Act for voluntary commitment doesn't allow that, does it?

A. Possibly.

Q. You testified that you are familiar with the voluntary sections of the Act. As a matter of fact, you testified that that is the main part that you are familiar with.

A. I did not say I was an expert on Pennsylvania Law. I said I read it.

So now if you are making a point about some aspect of it, I would appreciate you clarifying what you are discussing.

Q. First let me get your position. Your position is—

MR. ROTH: Why don't you first explain it. Let me object at this point. He is being misled.

MR. FERLEGER: I will do my best to be as clear as I can.

BY MR. FERLEGER:

Q. Your position is if a juvenile is allowed to admit himself or herself that it should be for as long as the psychiatrist (108) deems necessary; is that your testimony just now?

A. Yes. It should be on the basis of a psychiatric evaluation for admission.

Q. Now, for voluntary admission in Pennsylvania, the law, for your information, provides that under Section 402 a person can leave at anytime; and under Section 403 the commitment can be for no longer than 30 days with a provision that the person can give notice and then leave after 10 days, so those provisions would not satisfy what you see the needs of juveniles to be; is that correct?

MR. ROTH: This is an incorrect interpretation.

MR. FERLEGER: We will take a minute and let the doctor read the statute.

THE WITNESS: I really am getting tired. I think there has been a lot of redundancy in the questions that I have been asked, and I would like to take a break for coffee.

MR. FERLEGER: That's fine with me.

(Whereupon, a short recess was taken at 12:12 o'clock P.M.)

(Deposition continuing at 12:24 o'clock P.M.)

BY MR. FERLEGER:

Q. Doctor, with reference to this signing in and out of institutions, I believe the last question that I asked, which was not answered, was whether it was your opinion



that the voluntary commitment provisions of the law would not be appropriate for (109) juveniles since they do not allow what you said is the right procedure for the commitment to be as long as the doctor wants.

Is it your opinion then that the Pennsylvania voluntary sections would not be appropriate for juveniles?

A. I don't know what your question is yet since the question seems to be escaping me.

Q. Let's break it down into parts.

A. You're asking me to render an opinion about law in your state, and I'm only here to render an opinion about psychiatry.

Q. I am not asking you about an opinion about law.

You stated that it was your opinion that when juveniles, let's say, between 13 and 18 sign themselves into an institution or make that application, which you are in favor of, that that should be for as long as the psychiatrist thinks it is medically necessary; is that right?

A. And you told me that is the law.

Q. Is that right?

A. I said that a youngster should be able to tell somebody he is distressed, in pain and needs to be admitted, and then if that person is a psychiatrist that person should contact the parents or the guardians to take the proper procedure for admission. If the parents object and don't want the youngster admitted and the parents refuse to cooperate and the psychiatrist feels it is necessary, then he can call on the law to act in loco parentis.

(110) Q. And beyond that it was also your testimony that a child between 13 and 18 ought to be allowed to make the decision under Section 402 and 403?

A. By "application" I meant what I just said.

MR. ROTH: I have an objection on the basis that I don't think Dr. Sugar fully understood what you meant by "application" as far as the juvenile making the application or, as he stated numerous times, that if the juvenile is in need, then he should be able, the psychiatrist, after the evaluation, he should be able to indicate to the parents or guardian that an application should be made.

I think there has been some confusion with that, and that is what we are trying to clear up.

MR. FERLEGER: Well, we read the section of the Mental Health Act defining "application" and describing it, and Dr. Sugar—

MR. ROTH: I think he has clarified that point.

MR. FERLEGER: Well, your testimony is that if the juvenile's parents agree, then the juvenile should be allowed to get himself admitted with the psychiatrist's agreement to an institution; is that correct?

MR. ROTH: I object to that. He has not said that at all.

THE WITNESS: Well, I think you are misunderstanding and you are misphrasing what I just finished saying. I have (111) said it at least six times today.

BY MR. FERLEGER:

Q. And at six different ways.

A. No, I have not. I have said it explicit each time. I think this is unnecessary.

MR. ROTH: I object.



BY MR. FERLEGER:

Q. The Mental Health Act allows application to be made for admission to an institution by any person over the age of 18; for any person under 18 that application has to be made by other people.

MR. ROTH: That is exactly what I have just finished explaining, and I think you are asking a redundant question.

I object.

You are harassing the witness.

BY MR. FERLEGER:

Q. For people under 18, should that application—can that application, in your opinion, be in the best medical sense made by the juvenile himself?

A. I think I have just answered your question.

I refuse to answer your question again. I think it is in the record. If you want to read it, fine. I don't think I need to be going over the same ground again.

Q. Now, you testified to Mr. Roth that there would be a (112) problem if juveniles could admit and ask for their own release. There would be a problem with them going in and out of the institution; is that your testimony?

A. I said that if there were no psychiatric evaluations, this is not suitable.

I just finished clarifying that a moment ago that it had to be on the basis of psychiatric evaluation, diagnosis, recommendation; not on the basis of the juvenile being his own doctor.

I think I said that explicitly just 20 minutes ago.

Q. If there is an evaluation, do you feel it would be anti-therapeutic to allow the child to request to leave

when the psychiatrist's opinion would be that he or she should stay; is that correct?

A. Yes; but there is the availability of the law to have a hearing.

Q. Don't we have that same anti-therapeutic effect when an adult voluntarily requests to leave and the psychiatrist is in opposition?

A. Yes. The patient still goes out quite disturbed if he is not ready to leave yet.

Q. Now, Dr. Sugar, you testified with regard to operations in medicine or surgical procedures or physical problems that the child may understand and would be frightened, but that even if the child doesn't want the procedure that it should just be up (113) to the parents and the doctor whether or not the child gets the procedure; is that your testimony?

A. That's what I said.

Q. Are you aware at all of any legal provisions or limits which make it impossible for parents and doctors acting without regard to getting permission from the Court to make it impossible for them to decide on medical operations or surgical operations for children?

A. You're asking me for a point of law.

Q. I am asking you whether or not you are familiar with any legal principle which operates to limit the right of the parents to decide with the doctor as to what operations their children should get.

A. You're talking about ethical procedures or unethical procedures?

Q. I am talking about whether or not you have heard of any such legal principles.

A. I think you'd better clarify what you are asking me about.



Q. Have you heard of any such legal principles?

A. Can you clarify that?

Q. The legal principles I am talking about are those principles which prohibit or limit the right of parents acting with doctors to decide in their sole discretion what medical or surgical procedures are performed on children.

A. Where does that apply?

(114) Q. Excuse me?

A. Where does that apply?

Q. I don't understand your question.

A. Well, I am just rephrasing it to ask you to clarify what you are asking me.

Q. It applies to the situation where there are medical or surgical procedures which are contemplated.

Are you familiar with any legal principles in that regard?

A. You're asking me for a point of law—

Q. I am—

A. —and not medicine.

Q. I am asking you whether you are familiar, whether you have heard of any of those legal principles.

A. I have heard of situations where a youngster needed a tranfusion and, because of the parents' religious feelings, they would not. They would let the child die, and the Court would step in and have the medical procedure that was designated, the approved ethical procedure.

Q. Now, in a situation where an adult is advised in a medical, surgical context where an adult has advised that he or she needs a certain procedure done, and where it is not a question of life or death, it is true, isn't it, that the parents could refuse that procedure?

A. You are talking about an adult wanting to not go ahead (115) with the procedure that has been recommended?

Q. That's correct.

A. And you're asking if he has the right to refuse?

Q. In your medical judgment, what is your opinion?

A. Yes, he has a right to refuse.

Q. Even though one or two or 20 doctors may explain that it would be best to have that?

A. He has the right to refuse.

Q. Now, if that adult is told by one or two or 20 psychiatrists that the best medical procedure would be for him to be institutionalized, is it also your opinion that he has the right to refuse?

A. That is a question where the patient may not be capable of exercising proper judgment.

If you are talking about a physical condition and the assumption is made through the inference that the patient has his proper faculties for judging the situation and he refuses, it is a different situation from the very condition that needs to be tendered to as the one that is impairing his judgment and thinking processes. Then he is not in a position to exercise proper judgment about his condition and the need for treatment for that condition. So, it is not comparable to the physical situation.

Q. Is it your position that in a situation where a doctor counsels a certain surgical or medical procedure to be performed (116) on a chiid and with the parent agreeing that that should be outside the scrutiny of the law?

A. In the ordinary circumstances, yes.

Q. So, for example, if a young child had a healthy kidney which his parents and the doctor felt could be transplanted to another child who needed a kidney, is it your opinion that that removal of the organ should be just between the parent and the doctor?



A. That is not the ordinary circumstance.

Q. What is your opinion?

A. I would not render an opinion. It is outside of my field and specialization. I don't do kidney transplants.

Q. Well, you have rendered opinions about other medical procedures. Why is it this one that you decide not to render an opinion on?

MR. ROTH: Objection.

He has not rendered an opinion as to medical procedures. He has rendered opinions in terms of need and emergency for a condition that so warrants it.

MR. FERLEGER: I don't understand that.

THE WITNESS: I think what you are talking about is beside the point. I do not render opinions about medical procedures.

BY MR. FERLEGER:

Q. I agree that the medical procedures are beside the point.

(117) Mr. Roth brought them up in the questioning of you.

A. I was talking about these procedures that you are talking about of a kidney transplant being done on a child without his understanding and just because the doctor said so—that is not an ordinary circumstance.

I have already clarified my point. You are asking me to go into detail about a condition which is not in my area of specialization.

Does that clarify my comment?

MR. FERLEGER: No further questions.

MR. ROTH: I have no further questions.

MR. FERLEGER: Just for the record, since I came after Mr. Roth started the deposition, because I was later than I expected to be, I have not agreed to any stipulations with regard to signing or certification or filing or objections, and reserve the right to make any objections before the testimony is introduced.

MR. ROTH: You might want to show for the record what time the deposition began and what time it stops.

MR. FERLEGER: And the fact that Mr. Roth knew that I would be late.

MR. ROTH: By ten minutes, when he was late by 35 minutes.

MR. FERLEGER: I don't know of any proceedings in (118) the rules which allow counsel to begin a deposition without the other side being present.

MR. ROTH: Well, my understanding of the rules is that you are invited to attend, and the time is set forth, and as a result, we questioned Dr. Sugar about his qualifications and history and then the questions were read back to you prior to getting into the substance of the deposition, so we feel there was no prejudice whatsoever.



(Whereupon, the deposition concluded at 12:38 o'clock P.M.)

Reported by:
Marvin Dinter
Official Court Reporter

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Dr. Max Sugar

Dated:

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

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Civil Action No. 72-2272

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Kevin Bartley, et al,

Plaintiff

vs.

Haverford State Hospital, et al,

Defendants

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DEPOSITION OF DR. JOEL S. FEINER, M.D.
Philadelphia, Pennsylvania
August 21, 1974

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Oral deposition of DR. JOEL S. FEINER, M.D., held on August 21, 1974 at the office of DAVID FERLEGER, ESQUIRE, 1315 Walnut Street, Philadelphia, Pennsylvania commencing at 2:00 p.m., before Michael H. Stephany, Approved Court Reporter.

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Appearances

For the Plaintiff: David Ferleger, Esquire

For the Defendant: Barry Roth, Esquire, Room 323, Health and Welfare Building, Harrisburg, Pennsylvania 17120



(2) DR. JOEL S. FEINER, M.D., having been duly sworn, was examined and testified as follows:

Examination

BY MR. FERLEGER:

Q. Dr. Feiner, what is your occupation?

A. I am a Physician-Psychiatrist by speciality, Child Psychiatry by sub-speciality.

Q. Where are you employed?

A. I'm employed by Mott Haven Unit of the Lincoln Community Mental Health Center at the Albert Einstein College of Medicine.

Q. What city is that in?

A. Bronx, New York.

Q. Will you please tell us where you received your medical and psychiatric training?

A. After I went to college at Yale University, I received my M.D. at Albert Einstein College of Medicine. In 1964 I was a Pediatric Intern at Bronx Municipal Hospital Center, and took my residency in Child Psychiatry Fellowship at Bronx Municipal Hospital Center of the Albert Einstein College of Medicine. Completed my training in 1970.

Q. Since then have you been involved in any academic work involving Child Psychiatry or related fields?

A. Since that time, I have been both a service provider, (3) working with children and adolescents in the Lincoln Hospital, Department of Psychiatry and a faculty member of the Albert Einstein College of Medicine, currently holding the rank of Assistant Professor on a full-time academic faculty.

Through the years 1972 to 1974, I held a career teaching award recommended by the National Institute

of Mental Health. I understand that I was one of two recipients of that award from the country.

My work during these two years was to teach in the areas of community Child Psychiatry, which I proceeded to do, for a variety of personnel from medical students to psychiatrists in training, social workers, et cetera.

Q. Have you delivered any papers with regard to children or child psychiatry?

A. Yes. I delivered a number of papers concerned with adolescent phenomenon, particularly related to those phenomenon observed in the South Bronx area that I have worked. I have talked about street gangs in the South Bronx and graffiti phenomenon. I have also talked about children in the context of their schools, recently having delivered a paper at the American Ortho-Psychiatric Convention in April, 1974.

Q. Does your work involve treatment as a psychiatrist of children with emotional problems?

(4) A. Yes, it does.

Q. And also families of children with emotional problems?

A. That is correct.

MR. FERLEGER: Could this be marked as Plaintiff's Exhibit No. 1, please?

(Curriculum Vitae marked as Plaintiff's Exhibit No. 1 for identification.)

BY MR. FERLEGER:

Q. Dr. Feiner, could you identify Plaintiff's Exhibit No. 1, please?

A. Yes. That is a Curriculum Vitae which I have submitted.

Q. This is your resume?



A. My resume.

Q. And this resume includes your academic appointments and professional activities and papers and a review of your experiences?

A. That's right.

MR. FERLEGER: Will you please attach to the deposition that so we won't have to go over the rest of your qualifications?

BY MR. FERLEGER:

Q. Dr. Feiner, can you please give us a brief review of the kinds of emotional and psychiatric problems that children have (5) and then have those problems fit in with their relations with their families and other social agencies?

A. Well, the vitae is enormous, and ranges from everything from severely withdrawn and clearly psychotic children, who are virtually unable to relate to other people to the kinds of problems which we would consider to be situationally based. There are problems which result from the non-supportive nature of a particular environment, the inability of the environment and the child to mesh in a way that is conducive to the child's development. In between there are a variety of problems, various degrees of severity. What I, and any others certainly in the past five years have become extremely aware of is the relationship of a child's behavior and really his psychiatric symptoms to the entire context of that child's life. The usual context is the child's family, and what we talked about in recent years is rather than the kind of diagnostic approach where a child is diagnosed quite apart from the context of his life, and really in a kind of one-to-one interview. We are now very concerned with looking at the child from what we

might call an ecological context, taking into account all of the factors in the child's life, what that includes is recognition of the fact that children are extremely responsive to what goes on in families.

(6) Perhaps the most responsive element to the child's communication is hidden agendas, overt and covert needs of all of the members of the family, and since the early '40's we have known that parents can induce certain types of behavior in children based upon their own unconscious needs.

I guess a very simple analogy might be for the need to have a child behave in a particular way might be the need that is commonly recognized, for example for the public to go to football games or boxing matches. It is often said that this is an outlet, and it provides—it serves the need for people to funnel off some of their aggression, some of their excitement, much in the same way one might suppose that this need is ongoing, and a child is often the most easily available person to continually act out for the parents.

Another example of this would be the following—there certainly are certain families where the parents are simply not responsive to the usual kinds of—one might say good behavior or positive behavior. That behavior is simply ignored not acknowledged, and a child is not—does not receive any attention for that behavior. All of us need attention, and a good part of our life goes into ways in which we can receive attention from important people, and so a child finds ways that this attention is forthcoming, and very often that is what is (7) so-called bad behavior.

Q. Does that include behavior that in other context might give you this delinquent behavior?



A. That's right.

Q. So that a child's emotional problems or the stresses in the family situation could result in children acting in ways that might be considered delinquent or criminal as well as traditional mental health type systems?

A. Absolutely, and we might say after moralistically that bad attention is better than no attention at all.

Q. From the child's point of view?

A. From the child's point of view.

Q. Dr. Feiner, are you aware of any commission or any other psychiatric reports on the needs of children that have any conclusions that relate to the kinds of problems that you were just discussing?

A. Yes. There is, in recent years, a very important commission called the Joint-Commission on Mental Health of Children, and I have a rather extended quotation from a section of that that I would like to read. It is from the report of Task Force-2, which is "Studies of Children from Kindergarten Age through Eighth Grade." It is in the Joint-Commission on Mental Health of Children, Mental Health from infancy through adolescence published by Harper and Rowe, New York, 1973. This (8) is pages 112 and 113.

Q. But Dr. Feiner, is that report considered an important one in the field of Child Psychiatry?

A. Yes. It is an important one and one which has been widely discussed and written about in various sources.

Q. Doctor, do you have a copy of that report?

A. I don't have a copy with me.

MR. ROTH: Pardon?

THE WITNESS: I don't have a copy with me.

MR. ROTH: Where is it actually located?

THE WITNESS: It is located in any library which contains psychiatric references.

MR. ROTH: May I just register an objection on the basis of his reading it without seeing a copy of the report prior thereto?

BY MR. FERLEGER:

Q. Will you please read us the quotation that you have?

A. The quotation is as follows:

"The intervener ought to recognize the close interrelation interrelationships between the individual and his surroundings and deal with the factors that impinge upon the individual from the outside as well as from within the individual himself.

When the surroundings are not taken into account, there is, (9) for example, insufficient understanding of the social conditions of diagnosis, that is that psychiatric labels tend to stigmatize."

It goes on "All of these children are plunged from their natural environments and introduced to a different setting for a cure. If the child is treated successfully in this new environment, it is assumed that he can be sent back to his old environment to make a clean start. Unfortunately, however one could not remove psychopathology like an appendix. This traditional approach disregards the unfortunate fact that children often tend to conform to the niche in which they have been placed. A child labeled 'delinquent' may begin to consider himself a delinquent, and act accordingly. Furthermore, if the environ-



ment to which the cured child is returned has remained the same or perhaps even organized itself more firmly around old lines of interaction with the absent child seen as the only 'family problem', it seems highly unrealistic to expect the child to maintain this cure in the face of re-exposure to the elements which caused his disturbance."

Q. But Dr. Feiner, do you agree with those observations which you have just read?

A. Yes, I do.

(10) Q. And you would adopt them as your own?

A. I do try to put them into the practice of my own work.

Q. Dr. Feiner, from what you have said, I understand that there might be situations where the family's problems might result in the institutionalization of children; is that the case?

A. Absolutely.

Q. How would that happen?

A. Well, that would happen in a number of ways. The family is under stress from a number of different sources, often there are some intercurrent tragedies, such as separations, deaths, illnesses and the child, as part of that family is also under the stress. The child—everybody in the family experiences anxiety in different ways. The child's anxiety may be expressed dramatically, in which case the family, being overwhelmed to begin with, feels that their lot may be somewhat better if the child is simply out of the picture for a while. It is often very likely that under circumstances of stress, families will approach—what they consider experts, professionals of some sort or another, physicians, school personnel and so on and ask for some help, whereupon the advice that they get is that the child should be hospitalized.

They reluctantly follow that advice, feel guilty as a (11) result and the snowball effect continues as the family does not ultimately really receive help for its problems.

Q. Well, why would it be the child that would be scapegoated or institutionalized rather than another member of the family?

A. Well, the child is quite susceptible, and often it isn't the child—I mean there are many situations where the child does not go on, but the child has some intrinsic vulnerability based upon the fact the child is dependent to begin with, the child is more controllable in certain ways, the child is also often a newcomer to the setting, the last to be present in this little system, often unwanted, and un—not chosen.

There also is the important fact that children do represent for the adults a replay of their own childhood, and a re-experiencing of their own problems when they were children, so that the child is—the repository of the projected bad feelings of some parents towards their own childhood.

Q. So that the result in parent misunderstanding, the actions or feelings of the child?

A. Absolutely. Absolutely. I mean I would go on to say that this is certainly not unusual for parents to misunderstand or act in ways that are inappropriate towards their children.

Q. Well, do you feel, then that parents can be relied on to act in the best interests of their children?

(12) A. Well, I am sorry to say that the increasing statistics about child abuse and child neglect, the overworked bureaus of Child Welfare, I think speak to the point that parents do not always act in the best interests of their children.



I can recount tragic cases where that simply was not so.

Q. Now Dr. Feiner, the orientation of psychiatry that you have been discussing, has that always been the orientation of psychiatry or is that a recent change in the past 10 or 20 years?

A. Well, it is really within the past 10 years. There has been an increasing attention paid to the—what we might call the context of children's lives or the ecology of their lives, and this is so in part because we have just become technically more proficient as understanding group behavior and family behavior, and we now recognize how that behavior can be looked upon rather than isolating one element of that situation and assuming that all behavior and all symptoms are somehow self generated.

Q. Dr. Feiner, are you familiar with and have you examined the deposition in this case of Dr. Max Sugar, of Louisiana?

A. I have looked at some of it, yes.

Q. Now, not with reference to his entire deposition, but only with reference to those parts examined discussing his general (13) orientation in child psychiatry, how would you place him in terms of this change in orientation that you just discussed?

A. Well, I would say that he takes a traditional point of view, which isolates a child from the environment and discusses the child's behavior and symptomatology in very specific individual terms.

Q. By "traditional" you mean that orientation would be prior to the developments of the last 10 years?

A. Right.

I would also say, if I might that there is, in his testimony a kind of—what I would consider an inappropriate

sense that institutions can be taken for granted, that parents, schools, police and so on are institutions of good will. I wish that that were so, and maybe 20 or 30 years ago it was felt to be so in general ways.

Our experience certainly working in poverty neighborhoods is simply that these institutions cannot be taken for granted; that, as I have mentioned, parents do abuse and neglect their children and schools often do not even fulfill the mandate of teaching their students, let alone are they able to evaluate behavior.

Q. Dr. Feiner, you mentioned working in poverty neighborhoods. Now, in terms of the social class of children who are likely to (14) be institutionalized, what class would that be?

A. It very often is children of lower class—

Q. Is it correct that in terms of the various state hospital systems in the country, that it is more likely that lower class or lower middle class are patients there rather than the upper class?

A. It is my understanding that that is so, and in fact that often—the professionals who do the evaluations are at some great distance culturally, class wise and geographically from the situation in which these children are living, and misperceive behavior.

Q. Dr. Feiner, will you please tell us the general effects of institutionalization in mental institutions and especially how they may affect children?

A. Well, institutionalization is an extremely serious matter, especially mental institutionalization, extremely serious. First of all, there are no good studies, to my knowledge that really long range benefits are achieved from treatment. That, traditionally upon re-emergence into the community children are often, as I have said earlier, placed



in the same circumstances which they left, and the mental hospital has either done a sequestering of them from the real problems of their lives or an opportunity to participate (15) in some unreal world. Also the fact that problems have been dealt with by hospitalization has—is very often a first resort solution establishes mental hospitalization as an ongoing way that people should deal with their problems or that this child should deal with his problems in the future. Certainly we have to be very aware that there is a stigma that remains to mental hospitalization, and that a child at some point in his life will have to apply for licenses, have to apply for jobs, will have to account for this period of his life in some way, and we know that the reality is that the public does not look upon mental hospitalization as a benevolent benign situation.

The family is often stigmatized, and feels guilty as a result and looks, then for this person to behave in similar ways. After all, a mental patient, in our society is someone who has been in a hospital, someone who is psychotic and not in a hospital is not considered a mental patient. The operational definition of a mental patient is someone who has been in a mental hospital, and that brings with it certain expectations of the people around; moreover hospitalization sometimes obscures the kinds of permanent and environmental issues that I mentioned, it just tucks them away, and may never deal with them, and one may often get one child hospitalized (16) for family reasons, and then low and behold the family classes the next child in line in the family to start to deal with its problems.

Q. Has that happened in your experience?

A. Yes, it has happened.

Q. So that once one child in a family is institutionalized, you wouldn't be surprised, if, after a period of time,

the next child develops some problems and becomes institutionalized?

A. It has happened in my experience, when the family has not been dealt with.

Q. Dr. Feiner, it seems from your testimony, then, that you consider treatment by physicians in mental hospitals to be somehow different than treatment for physical problems of children in community or even in a general hospital such as a tonsilectomy or some disease that requires hospitalization in a regular hospital?

A. Well, I do, because if one were to bring a child with tuberculosis to a doctor—and this is really a similarity, in a way, one would test all of the people in that family for tuberculosis and treat them, if one found tuberculosis. I feel that taking a child to a psychiatrist for treatment is different in part because there are qualities of this child having a contagious disease that needs the entire situation, as I (17) mentioned previously, that needs to be looked at, and the response of the environment or of the psychiatric institution has many alternatives.

Q. Dr. Feiner, since this lawsuit involves an attempt to attain judicial hearings to explore alternatives to institutionalization and the needs for institutionalization, are there alternatives for treatment of children who need mental problems that a court could explore or is hospitalization the only possibility?

A. No. There are alternatives that I would expect ought to be used even before it gets to a court. These are by now tried and true situations.

I will refer to one of them which is a study called "The Treatment of Families in Crisis." In the results reported in this book, which is by Drs. Donald Langsley and David Kaplan, 75 patients who would normally be admitted to a hospital were matched with 75 controls, all of whom were admitted to hospitals according to usual procedure. The 75 patients who were treated in a family context with intensive rapid intervention of a variety of various ways showed 85 percent less hospitalization over 6 months than those who would have been hospitalized in the regular way. This saved all of the problems of being hospitalized and is a dramatic way of (18) relieving stress in a family and working in a problem oriented way towards the supportive and human and quite appropriate resolution of family problems.



After all, the family often comes in in panic, has—they have exhausted their own repertoire of behaviors and solutions, and often it is common in and of itself for someone to say "Calm down, I think we will be able to help, let's see what the problem is. Maybe all you need is a good night's sleep, which I can help you have, and let's talk about it and see what resources are available." This worked initially in 75 out of 75 and then over 6 months only 17 percent of those 75 had to be hospitalized.

Q. Now, is this an accepted alternative, then, without hospitalization?

A. Absolutely. It is an accepted alternative which requires a vigorous effort on the part of mental health personnel.

Q. Now doctor, the calming effect that you just described reminds me of Dr. Sugar's testimony where he testified that when a child is brought into an institution, a mental institution, there is very often a sudden, you know, relief of stress, and the child—almost says—feels good to be there. Now, is there any other explanation besides the beneifts of hospitalization that might explain that relief?

(19) A. Well, in an ironic way that in part may speak to the situational nature of the child's problems—that the child hasn't gotten any therapy yet, there hasn't been any internal reorganization of his character structure, he just has had a situational environmental manipulation, and what I am suggesting is that can be done while the child is still there with an objective parent, who is human and sensitive to the needs of this family, and I would say that calming effect could in fact be just a non-specific relief that somebody is doing something about a situation.

Q. Dr. Feiner, most often—and you can confirm or deny whether this is actually true, but it appears to me that most often psychiatrists to whom parents bring their children or parents are directed to bring their children learn of the symptoms and the background of the behavior of the children from the parents, and I wondered if you could discuss, as you have peripherally earlier, whether or not parents are reliable sources for that sort of information?

A. Well, I am not sure that anybody who is experiencing tremendous anxiety is reliable for this source of information. I think that they, too, are very much in the situation and obviously can't be objective reporters of the situation. Clearly what they have to say is important—I wouldn't deny (20) that their information is important, if not crucial; however, it is only one of the part of the whole thing. Very often we see a child, mental health professionals will see a child on one occasion and make an evaluation that really needs to be thought about, because a child is going to be either overly anxious and show behavioral manifestations or withdrawal, because of the unfamiliarity of the setting, the kinds of feelings that the child has that this interview is going to determine the child's fate for a good period of time, and there is no sense that this—that



this situation is in the child's best interest. So likely what a psychiatrist would observe is artifact, to some extent.

Q. So then the kind of brief evaluation that patient or potential patient would get, as under the state's regulations and the statute involved here, either at the hospital upon admission or by a referring agency, that kind of examination might not be the best way to really find out what is happening with this child?

A. It might not be the best way.

Q. Now doctor, there is some dispute in this case as to who should determine the facts involved in a particular child's situation. In other words if the child is accused of behaving in a certain way, if that is true, it might mean one thing to (21) a psychiatrist, and if it is not true it might mean something else. Now, do you feel that psychiatrists are social agents who are best qualified to make those kind of judgments or should it be a judicial or other sort of thing—partial agency?

A. Well, I think that when it comes to the point of determining facts for the purpose of making major and dramatic alterations in a person's life, that we need help, that we are—the facts that we are used to gathering are often the psychological facts which require some interpretation and some subsequent validation. We do not always have the access to the facts, although in some contexts, such as crisis intervention were, we try to get it by immediately making home visits, by immediately going to schools, by trying to gather as much information as quickly as we can, but we are really taught to evaluate emotional experience, which often is the person's interpretation of the outside world, and not the outside world itself.

Q. Doctor, from what you have said, and based on your professional experience, do you feel that for children

19 years of age and under that a pre-commitment hearing to determine the need for hospitalization is appropriate?

A. Well, let me say, if it comes to that, it is appropriate. (22) From my point of view it would certainly would be that there are many things to be tried first, and many ways of responding to paying, and—but if it comes to that, it certainly is appropriate.

Q. Doctor, do you feel that a requirement by the law that there be a pre-commitment hearing rather than parents being able to apply for institutionalization that that requirement would encourage psychiatrists or parents to explore those alternatives?

A. I would certainly hope that it would, that this would underscore the serious nature of hospitalization and cause people to have second thoughts, and to search out various alternatives such as one that I have mentioned earlier.

Of course there are others.

Q. Now Doctor, can you explain why, for both the children involved and for the family a judicial hearing might actually be therapeutic or beneficial?

A. Well, I think if it reaches that point, it is very likely that the child—if the child is the one that is refusing the hospitalization is feeling rather helpless and hopeless, and feeeling rather abused, and unable to turn to anyone, I would say at this point, being very crucial that the child have a Advocate to diminish the possibilities of the hopeless and (23) helpless feeling. After all, an important reason why many children set up, set out, and do whatever they do that may have caused them to get into the hospital is because they feel hopeless and helpless, and to be forced into a situation in a similar way is reinforcing this feeling. Then, if they get into the hospital in this situation,



they have been coerced, and it is extremely difficult to treat anybody who is being in treatment under all the mayhem or coercion.

Now, for parents they often are hospitalizing the child because of other people's suggestion, and ongoing support for this procedure. It may in fact be very supportive for them to submit the situation to an independent kind of evaluation, which would then relieve them somewhat of the subsequent feelings of guilt that they may have.

Q. And that independent evaluation could be the testimony of a psychiatrist before someone appointed by a court or a court and an airing of both sides of the story?

A. Yes.

Q. In the courtroom?

A. Yes.

Q. Dr. Feiner, have you read the Pennsylvania statutes that are involved in this case?

A. Yes, I have.

(24) Q. And have you read the regulations recently promulgated by the state regarding conditional safeguards for children?

A. Yes, I have.

Q. Do you have a copy of those regulations with you there?

A. Yes, I have.

Q. These regulations are the regulations that I published in the Pennsylvania Bulletin, Volume 3, number 37, page 1840 and they are part of the record of this case with reference to these regulations, which only apply in some parts to children between 13 and 18, do you—will you please comment on the appropriateness of the notice to children of those ages which are read to them. Do you feel that that notice is likely to be understood by children or misunderstood?

A. Well, I think for two reasons, essentially it is likely to be misunderstood. One it will be read to a child when there will be many other things on the child's mind—getting used to a new environment, "What am I doing here, I feel abandoned, I feel helpless—" and so on.

Secondly it is in language which is extremely difficult for an adolescent to understand. If this is to be read to children at least let it be read in such language that is attentive to their level of comprehension.

Q. Now Dr. Feiner, if a child who is admitted to an (25) institution in the manner now under the law objected under these regulations and then after a court hearing was released back home and found not in need of hospitalization, could that have any bad or negative effects on the child?

A. Yes, clearly if the parents have gone to this length, they will be resentful. They are likely to take it out on the child, who is the most immediately available scapegoat. The child will feel resentful. There has been no communication established between them, and it is likely to have a very destructive effect. I would also say that none of the other possibilities or alternatives are elaborated in this statement, so the child may simply say "I want to remain here, because this is known, I am already here," and the other alternative is "I don't know, I'm going to take the safest place for now, because I am already here."

Q. So that would be a reason that children who really do object wouldn't want to say so?

A. Yes, it would be.

Q. Now, the negative effects of getting to the hospital and then leaving after a hearing which results in a finding in favor of the child, is it your opinion that that



would be a reason to have the hearing prior to the commitment?

A. I think that there is good reason for having it prior, (26) so that other alternatives can be looked upon without having any more steps interposed.

Q. Dr. Feiner, for children under 13, do you feel there is any need or reason to have an Advocate or some procedure to examine the institutionalization of those children?

A. Well, we often do have Advocates for children under 13. Bureau of Child Welfare is an Advocate in our city for children under 13.

Q. You mean in other contexts?

A. In other contexts, right, and I think that contexts can be extended. As I said, there may be the perception or the experience, rather of feeling hopeless and helpless in this situation if the child's needs are not being met.

I would also say about school age kids, and adolescents, that there is particular attention that they pay to issues of fairness, that fairness and what is just is a very important issue in the development of children—of school age and of adolescents, and we often see children being able to repeat rules and to have clubs with very elaborate guide lines to follow so that they are very sensitive to issues of fairness, and it has been said that some children would rather be fair than be loved. So, there is a sense that a judicial hearing responds to in children.

(27) Q. Dr. Feiner, with reference to the need or the desirability for having judicial commitment hearing for mental hospitalization, could you tell us whether you think there is any special difference in the psychological make-up of adults, vis-a-vis children which would mean that it

is appropriate for adults to have hearings but for children not to have hearings?

A. Well, I would see some differences, but I could see them even in answering the reasons for children to have hearings—I mean adolescence is a period of life where—in which the person experiences the feeling of being an outsider. One can see this in the kinds of identifications that adolescence makes of minority groups or outlaws, all kinds of outsiders, so the adolescent often has the outsiders view of injustice, of being alone, of being isolated, of needing some kind of contact and so forth, and if it is not readily forthcoming from one's immediate environment, which it often is not, then one needs it from someone else, and the presence of a lawyer or at least a court hearing, as that possibility can be reassuring.

MR. FERLEGER: You may cross-examine.

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*Cross-Examination*

BY MR. ROTH:

Q. Dr. Feiner, now it is my understanding that you became a psychiatrist in 1970; is that correct?

(28) A. No. I finished my adult psychiatric training in 1968.

Q. And you finished your residency in '68?

A. '67 and '68, right. I combined the third year of my residency with the first year of my Child Psychiatry sub-specialty training.

Q. Have you offered any articles in the field of Child Psychiatry?

A. I have given professional papers, but I currently have not offered articles.



If I may say so, I have been working providing a service for 12 hours a day over the past—at least 5 years.

Q. But you haven't offered any articles; is that correct?

A. That's correct.

Q. Doctor, now when you finished in—did you complete this course of Child Psychiatry in 1970, then?

A. That's correct. I took an extra year of Child Psychiatry so I could work half-time for 2 years in a hospital in a ghetto area of New York City.

Q. When you completed in 1970, did you become affiliated at that time with Lincoln Hospital?

A. That's correct.

Q. What was your role at the Lincoln Hospital?

A. At that time I was the only Child Psychiatrist on the (29) staff, and was responsible for service and supervision of children on an outpatient basis.

Q. Now, is Lincoln Hospital a private hospital?

A. No, Lincoln Hospital is a New York City hospital.

Q. You were responsible for children on an outpatient basis; is that correct?

A. That's correct. Children and adolescents.

Q. But the hospital, I assume also maintained institutionalization on an inpatient basis; is that correct?

A. There were institutional facilities available, but not in the hospital itself. The hospital is located in a very poor area and needs to go elsewhere for its inpatient beds.

It is a sad fact of life.

Q. How would a patient come to you at Lincoln Hospital?

A. The patient would—

Q. In terms of—

A. You mean child?

Q. Child, yes.

A. Most of the time the patients were sent by the schools. Over 90 percent of the children were referred from the schools. Occasionally they would be referred from other agencies or from pediatric departments, and very occasionally would they be self-referred.

(30) Q. And these children are from a ghetto area, I take it?

A. That's correct.

Q. Are you still associated with Lincoln Hospital?

A. I am currently associated with the Lincoln Community Mental Health Center, which is a different facility.

Q. And what is your role at the Lincoln Community Mental Health Center?

A. I am the Director of a Satellite Clinic, and responsible as well for all the child psychiatry that goes on there.

Q. And in terms of your role, how does a patient come to you at that Mental Health Clinic, a child?

A. Exactly the same way, only in this case I have developed programs which have more outreach possibility—potential.

Q. Do you ever have a situation occurring where your evaluation of a juvenile requires institutionalization?

A. Very occasionally, we do.

Q. And what is the process, then?

A. The process is first to work in terms of the child of an approach that I described earlier, that we have on our staff a number of people who are from the community. We are located right in the community. It is extremely easy, and important to us that we go to the source of the complaint—if it is the school, we may go there or request



that the (31) school personnel come to our clinic. If it is the family, we will likely make a home visit. We will extend ourselves in every way possible under the constraints of time and personnel that we have there to try to resolve the problem in ways that will avoid hospitalization.

Q. Now, assuming you have explored all those other alternatives, what occurs then, where it has not been successful to utilize another avenue for treatment?

A. Occasionally there will be need for hospitalization. I am not denying it.

Q. And then what happens, who admits the juvenile in New York?

A. There is an admitting hospital, which is another City hospital, and there are—actually there are a couple of ways that this can be accomplished. There are occasional needs for emergency hospitalization.

Q. I am not talking about emergency hospitalization.

MR. FERLEGER: Mr. Roth, can you let him finish his answer before you interrupt?

MR. ROTH: Well, I will rephrase the question, Doctor, so we won't have to go on avenues that we don't know because of time.

BY MR. ROTH:

(32) Q. With regard to non-emergency—

A. With regard to non-emergencies, we usually have a variety of treatment facilities available to us. We then participate with the family and the child in investigating those facilities. We make a visit with them. We talk to the people there, and we go through a procedure in which the family and the child have the opportunity to freely discuss their opinions of this particular place. We have some

residential treatment centers. We have a children's hospital, which is part of the state system, but what we do is we participate with the family and the child in this procedure.

Q. In terms of admitting a juvenile to an institution, who can do it in New York?

A. In terms of admitting, on an emergency basis?

Q. On a non-emergency basis?

A. On a non-emergency basis, a community physician can do it, I believe and the psychiatrist in the receiving hospital.

Q. Isn't it a fact true, then, under New York law only the parent, legal guardian or next of kin or the application of the director of the institute can admit the juvenile?

MR. FERLEGER: I believe that New York statutes on which the court can take judicial notice would answer that question. I don't think that Dr. Feiner is (33) qualified to speak authoritatively on what the New York statutes say. I think the statutes speak for themselves.

THE WITNESS: What I would like to say—

BY MR. ROTH:

Q. Doctor, with regard to that question now, you have already testified as to admitting procedures, and I am questioning your familiarity with New York law on these procedures.

Now, is that not in fact the case on how a juvenile can be admitted?

A. I believe that it is.

Q. What is the distinction?



MR. FERLEGER: Excuse me, have you finished your answer, Dr. Feiner?

THE WITNESS: Well, I want to suggest operationally that we proceed very much as the child and parent advocates. We consider ourselves to have an ongoing relationship with them, in pursuit of a proper treatment for the situation, and we will have exhausted other community based possibilities before we pursue any kind of hospitalization.

BY MR. ROTH:

Q. Now, in terms of juveniles and their admission process in New York, is it similar to the laws of Pennsylvania?

(34) A. For 16 to 18, the patient has been given notice in writing to the director that they desire to leave.

Q. What about the admission of?

A. An admission, under 16, they can be received as voluntary, on the application of the parents, guardian or next of kin?

Q. And after 16?

A. After 16 the director of the hospital may use his discretion in deciding whether to admit or not.

Q. With regard to release?

A. With regard to release, my understanding is that the patient gives notice in writing to the director of their desire to leave. They must be relieved unless they are—it is an involuntary commitment, at that point they can apply—the hospital can apply for a court order within 72 hours, the date for the hearing must be given no later than 3 days from the time the court order is received and the patient, if the decision is made to commit them, the patient is committed for a period not exceeding 60 days.

Q. Doctor, now with regard to that, is it your understanding of the New York law that if a patient is under 16 years of age that patient may notify the director of his release?

A. That is my understanding.

(35) Q. And the patient—is it finally your understanding that the patient can be detained at the institution for 72 hours during which time a county court or the Supreme Court should be notified? Is that correct?

MR. FERLEGER: I have to object, again to this whole line of questioning in Mr. Roth's attempt to get the New York statutes into the record through the words of somebody who is not a lawyer, who is not familiar with the case law in New York; not familiar with amendments which may have been enacted now or a year ago or 2 years ago under the New York statute. I see Mr. Roth has a copy of the New York statute, and I am sure if he wants to introduce that as an exhibit to save Dr. Feiner's time and to acknowledge the fact that he is not an expert in the law, I wouldn't object to the New York statute being introduced as an exhibit. I don't see any necessity for Dr. Feiner to contend to be an expert in the law. He is a Child Psychiatrist, not a lawyer.

BY MR. ROTH:

Q. Dr. Feiner, with regard to the questioning that I have been imposing, in terms of the release provisions, now, you have already testified that you are somewhat familiar with the admission and release procedures, I would assume, in New York with regard to the release provision. Is it your understanding (36) that a patient can be detained 72 hours?



A. That is my understanding.

Q. And thereafter, according to court order, could be detained as long as how many days?

A. No longer than 3 days from the time the court receives the notice.

Q. And then when does the hearing occur, do you know?

MR. FERLEGER: The record will show that Dr. Feiner raised his hands in a shrug of speculation.

MR. ROTH: I think Dr. Feiner is capable of answering, either yes or no or explain it.

THE WITNESS: I am not sure of the answer to that question.

BY MR. ROTH:

Q. Have you ever been involved in any of these proceedings?

A. With the court? No, I haven't.

Q. With regard to—I notice in answering some of our questions on the admission and release procedures you were reading from something. Could you explain what you were reading from?

A. I happen to take down some notes from Section 3113 of the New York State statute.

Q. Dr. Feiner, are you aware of any judicial proceeding in (37) New York prior to the admission of a juvenile by his parent under 16 years of age?

MR. FERLEGER: That is totally irrelevant to this case whether or not Dr. Feiner agrees with or disagrees with New York law. He, of course like all of us obeys the law in New York and doesn't make his own laws, and whether or not there is a judicial

proceeding in New York doesn't matter in terms of his testimony, just as his testimony isn't affected by the fact that in Tennessee similar laws are ruled unconstitutional.

BY MR. ROTH:

Q. Not withstanding the testimony by opposing counsel, his objection is noted, would you answer that question?

A. I would simply say that I follow the law as I understand it when the situation arises. I—if you are asking me my opinion of the law—

Q. I am not. I am asking you if there are any judicial proceedings afforded a juvenile prior to admission by a parent in New York.

MR. FERLEGER: The law speaks for itself.

THE WITNESS: I would agree.

MR. ROTH: I would appreciate, Mr. Ferleger, if you would allow your client and your witness to answer or if (38) you would object accordingly.

THE WITNESS: I have availed myself of immediate access to legal advice as a condition of my work. I have a number of lawyers who are quite familiar with this law, immediately available to me for advice when these matters arise.

BY MR. ROTH:

Q. Doctor, now you testified, and I will come back to the admission procedure, but with regard to some other things, you testified that the children's behavior, in many instances is a result of the environment in which he is located. Now, is it your testimony that many juveniles are



the scapegoats of familial problems, and as a result find themselves in institutions?

A. Yes, I will.

Q. And how do you arrive at that opinion?

A. I arrived at that opinion by making an evaluation of a family situation, which I think has as much or if not more legitimacy as any valuation of any individual child. We simply do it by an evaluation of a family, of a family setting with the child often in his family, and we do the interview on occasion with the entire family.

Q. Well, how many juveniles have you seen institutionalized (39) in New York incorrectly as a result of family problems?

A. Many. I would indicate at the same time that the diagnostic interview is not only a diagnostic interview, the interview is an attempt to defuse a potentially explosive situation. This family has come in crisis. We do not set ourselves apart, and do a detached kind of interview. We are very active, and very much desirous of defusing this situation and orienting ourselves to this family's problem.

Q. Okay. You practiced, I recall in a ghetto area; is that correct?

A. That is where I—that is where my clinic is, that's correct.

Q. Do you find that most of the people in that area avail themselves of either the law or medicine when they need it?

A. I don't know what that means.

Q. I mean do they make use of contacting their neighborhood legal service attorney or their community oriented physician or are they afraid to, in many instances?

MR. FERLEGER: That question is so vague. Of course sometimes people do. Sometimes people don't.

MR. ROTH: Mr. Ferleger, if you want to object, I don't like the idea of your testifying on behalf of the (40) doctor.

THE WITNESS: Obviously sometimes people do, because all of us that work there in any service capacity are overwhelmed, and whether we reach as many people as need our services, I can't tell you and I seriously doubt it.

BY MR. ROTH:

Q. Do you find that because—obviously I would think you would have some understanding of the environment in which you work that either people are hesitant or reluctant to contact attorneys or doctors.

A. Or people are simply demoralized and overwhelmed with such a variety of problems, that it is hard to set priorities, and their experience with service agencies is so demoralizing that they seek other solutions, often desperate ones.

Q. Do you feel that by having a juvenile participate in a judicial proceeding prior to any admission, that this may cause a reluctance on the part of any parent to utilize this system in that area?

A. I think it would certainly dignify the whole system to the juvenile.

Q. I didn't ask you that, I asked you whether or not it would?

A. I would tend to think not, because my experience often is, (41) as I have mentioned, that parents very often are there at the behest of another agency, such as the



school, and they are doing it because somebody who they have been led to believe has their interest in heart has sent them to a facility, and they are going ahead with it, because they feel that the consequences of not going ahead with it are worse, and they have been led to believe that hospitalization can be a benign situation, so I would say that very often availability of legal help in these situations is a tremendous relief to everybody involved.

Q. Now, in Pennsylvania are you aware of how a juvenile may end up at an institution?

MR. FERLEGER: The question is not clear as to whether you mean whether the statutes are in the doctor's awareness.

MR. ROTH: I am asking the doctor—of course he is aware of the sections being questioned, and I am also asking practically if you had any awareness.

THE WITNESS: No practically I haven't. I haven't worked in Pennsylvania.

BY MR. ROTH:

Q. Okay. With regard to the procedural safeguards, if you will that I attached to a juvenile—

(42) MR. FERLEGER: Are you referring to the regulations?

MR. ROTH: Yes.

I believe there was a statement made earlier by your attorney—

MR. FERLEGER: I am not Dr. Feiner's attorney.

MR. ROTH: By counsel for Plaintiffs, who is using you as a witness, that there was a brief evaluation done prior to admission of juveniles in institutions.

Now, according to your reading of the regulations, do you find that necessarily—do you find any words in there that say "Brief evaluation"?

THE WITNESS: No.

BY MR. ROTH:

Q. Now, with regard to the process in Pennsylvania, there are base service units. Do you know what base service units are?

A. I do not.

Q. With regard to the procedure in Pennsylvania whereby a juvenile is—well, let me ask you this, strike that.

What is your understanding, based upon your reading of the regulations of how a juvenile would arrive at an institution?

MR. FERLEGER: I think the regulations speak (43) for themselves. If Dr. Feiner wants, he can read them, because the only thing he has to base his understanding on is a text of the regulations, so any interpretation of that would be irrelevant and superfluous.

MR. ROTH: Well, the question remains doctor, and it is essential, as you know, Mr. Ferleger that Dr. Feiner knows what is in question, and his opinion of the same, and I am asking you, based on your reading of the regulations and so forth, can you tell me what your understanding of Pennsylvania procedures are for the commitment of a juvenile?



THE WITNESS: I do not understand—it does not indicate the patient flow, if you will. I have simply been made aware that there [are] a number of juveniles who end up in a hospital still against their will regardless of what is presented.

BY MR. ROTH:

Q. And how did you arrive at that factor that juveniles are hospitalized against their will in Pennsylvania?

A. I have been apprised through the material furnished regarding this case.

Q. What specific instances are you referring to?

A. Well, I would say in general that if I am asked about—I mean if you want to ask me some specifics about some specific (44) cases, I would be happy to comment on them. I think I actually am, in testifying in regard to the involuntary hospitalization of juveniles.

MR. FERLEGER: I might note for the record that Mr. Roth has stipulated to tables and statistics which were written with his assistance and help indicating that juveniles do in fact on occasion object to commitment, and that, it seems to me, is not a disputed aspect of this case. We know that some children don't want to be in hospitals and some children do.

BY MR. ROTH:

Q. There is no dispute as to the objection. The question remains as to how you know that juveniles are incorrectly admitted to institutions in Pennsylvania?

A. I did not say incorrectly.

Q. Inappropriately?

A. I said "Against their will."

Q. Now Doctor, with regard to some of the comments you made of Dr. Max Sugar's deposition, did you ever hear of Dr. Max Sugar?

A. I believe I read something that he has written. I have seen his name.

Q. Do you know, in review of that deposition, which you (45) said you have done—

A. I said that I did not do an entire review of it.

Q. What parts of it did you review?

A. I read about half. I read his depostion and you were questioning of him.

Q. Pardon me?

A. I read his statement with your questioning. I did not get beyond that.

MR. FERLEGER: You are referring to the direct examination of Dr. Sugar by Mr. Roth?

THE WITNESS: That's correct.

MR. FERLEGER: You read that?

THE WITNESS: That's right.

BY MR. ROTH:

Q. Do you recall Dr. Sugar testifying as to the problems that would occur if a judicial hearing were afforded prior to admission?

A. Yes. I recall that.

Q. With regard especially to the delay in treatment?

A. Yes.

Q. Do you feel that is an incorrect response?

A. Because—yes, I do, because as far as I am concerned, treatment begins the very first time that the patient, and/or (46) family steps foot in any mental health facility; that, to me is when treatment starts, not at some point at which somebody enters the ultimate door.



Q. But again, Doctor, taking into account, if you will the procedures in Pennsylvania whereby children are just not placed on doorsteps of institutions, but have been subpoenaed and evaluated by several psychiatrists prior to the ultimate detention of them—

A. Yes.

Q. Don't you feel that there has been adequate safeguards provided at that point?

A. No, because I question the evaluation, and as to whether it takes into account the entire context of the child's life.

According to Dr. Sugar, he would evaluate the child and he does not seem in the testimony to be entirely responsive to the kinds of communications that go on in the family, and he seems to assume in his testimony that parents exist all the time for the good will and the best interests of their children. I question that seriously.

Q. Now Doctor, you did not read the cross-examination, I take it of Dr. Sugar's cross-examination?

A. No.

Q. In which questions were asked by Mr. Ferleger, regarding (47) the whole familial situation?

A. Yes.

Q. So then I guess it would be difficult to ask you questions with regard to Dr. Sugar's responses?

A. I think so.

Q. Since he did take into account the entire family situation at that point?

A. My only response to that would be that it can't be a primary importance to him if he did not mention that on initial or direct examination.

Q. Well, there are some things in regard to it on direct, but let me ask you, as a professional, do most psy-

chiatrists just evaluate a child, a juvenile without evaluating the familial situation?

A. There are different ways of evaluating the familial situation, very often it will be done discreetly—that is one person will evaluate the child, one person will evaluate the parent, another person will interview the other parent. This is a traditional way that is often done in child guidance clinics.

What I am suggesting is myself and many other people see everyone together in the family, whereby different kinds of information are forthcoming.

(48) Q. Are you saying, then, that it is not customary for a psychiatrist to evaluate the entire situation from whence a patient comes, a prospective patient?

MR. FERLEGER: That has already been answered.

MR. ROTH: I am asking you that question.

THE WITNESS: That it is customary to evaluate the entire situation to develop supportive evidence for the disturbance of this child? It often is done to get history of this child, which the child himself cannot furnish, but very often it is done in order to get an understanding of a parent's own life and a parent current situation.

I can give you some examples.

BY MR. ROTH:

Q. Well, that is all right.

MR. FERLEGER: He is concluding his answer to your question.

THE WITNESS: Let me give you one example.



A child that I saw ran away—brought in to see me when he was found some miles away from where he lived. This was an 8 year old child and taking the history of the family situation, it was discovered that this child was in fact not the child of this father, but the child of another father who ran away from the family. This was a secret which the family (49) had a tacit understanding of keeping. Nobody was allowed to talk about it, but everybody knew it, including the child, because he was 3 years old and other relatives had supported his sense of what was going on. The fact that the family couldn't talk about it meant the child had to act it out, which he did and this was his way of dealing with an issue that was not allowed to be talked about in the family, but had to be acted out in terms of this child being like his original father, trying to find his original father and so on. As soon as this issue was opened up and discussed openly, the running away ceased.

There is an example of a child whose behavior was induced by the collusion of his current parents.

BY MR. ROTH:

Q. Are you saying that is a normal, that generally parents and psychiatrists act in collusion or conspiracy to institutionalize an individual?

A. No, not at all. I am saying that very often for their own needs and their own anxieties and the complicated aspects of their own nature, parents may in fact be unable to talk about certain aspects of their lives openly, and I would say that it is not always recognized that these situations occur, and even if it is recognized, I am saying it is not always dealt (50) with—you see that is the other

part of this, you see even if the psychiatrist does do an evaluation of the situation, it still does not lead to the implementation of a treatment plan that includes the entire family or that includes a psychiatrist orientation, in part because many facilities are just not tooled up to do crisis work, and they only have one alternative, which is to hospitalize.

I am suggesting that it is important that clinics and emergency rooms and other facilities be tooled up to intervene immediately so that whatever facts they do discover can be included in an appropriate treatment plan.

Q. Well, you said that when any great alteration occurs and you felt that psychiatry should not be able to make the determination, that they should submit their evaluation. Would that also occur for any other treatment plan other than institutionalization, in your mind?

MR. FERLEGER: I object to that question. I believe he has already testified that institutionalization is a much different, more serious process than other kinds of treatment.

THE WITNESS: I will consider Mr. Ferleger's objection to be consistent with my belief.

BY MR. ROTH:

(51) Q. Now, you stated that Dr. Sugar talks about the traditional point of view and that your point of view is more innovative; is that correct—or better?

A. I'd say that.

Q. Based on your experience, I mean?

A. I'd say that my point of view offers more alternatives.

Q. Is your point of view better, based on your three years of experience?



A. Does it help me for people? Does it work for me? Does it work for others that have used it? Does the literature say that it works? I'd have to answer yes.

Q. Well, where do you arrive at this new innovation?

MR. FERLEGER: Excuse me, that is a total misstatement of his testimony.

THE WITNESS: Absolutely. I have no—I'm sorry—

MR. FERLEGER: He stated on the report that this is a development in the total field of child psychiatry over the past ten years. Dr. Feiner didn't think it up, it was taught to him and every other person who studied child psychiatry in the past ten years. It is Dr. Sugar who is behind the times. We are not talking about innovations, we are talking about regular practice established—accepted (52) practice.

BY MR. ROTH:

Q. Well Doctor, let me ask you this:

If this is established practice, why is the first state or one of the few states whose statutes and laws are becoming attacked as unconstitutional, why aren't other states utilizing judicial procedures prior to admission of juveniles by parents, if this is so recent or if it has been going on for ten years?

A. What I am suggesting is that what is going on for ten years is a treatment motility that I am suggesting be applied for more situations than it currently is. It is likely that it is being applied in many places in Pennsylvania. I simply am reflecting to you the current state of the art as I know it, from what I read and the meetings that I attend and the colleagues I consult.

Q. Let me ask you this, in terms of what goes on in Pennsylvania and for example if I had a child and were having that child admitted to an institution, as the ultimate, if you will and so I went through—let's take it, if I were from a poor socio-economic background, could not afford a private psychiatrist at the outset to evaluate my child, et cetera, et cetera, including home life or anything which you might think was relevant which goes on in Pennsylvania and I went to this (53) base service unit where I evaluated my child, made recommendations they went through their entire process, okay, and then there was a recommendation that the best alternative, after making other recommendations of other outpatients through the county mental health mental retardation unit, of which there are numerous ones throughout the state, if they found in the best interest of the child that institutionalization would be a paramount and then I went to the institution and the director, then, according to the laws as you have read them in Pennsylvania has another independent psychiatric examination made to make certain that the child does not need institutionalization and that occurs and the child is detained in the institution receiving treatment, knowing full well that according to the safeguards that he objects at any time within 48 hours thereafter he is going to be afforded counsel and go through a hearing, do you find that to be inappropriate?

A. You say so much that, first of all I question the child is already receiving treatment. I think a child strongly believes that he is not—that he does not feel that it is necessary for him to be in an institution is not likely to acquiesce to the kinds of appropriate treatment within the first 48 hours, so I can certainly question that aspect of your assumption.



(54) Q. Well, Doctor let me clarify something, so you don't misunderstand this.

It is not necessarily within the first 48 hours, it is within 48 hours whenever he makes the objection, if he makes the objection at admission or subsequent thereto—we are talking about within 48 hours after that objection counsel will be afforded him?

A. Yes. I simply am saying I do not see why it can't be done before hand. After all, you have talked about an elaborate procedure that goes from one place to another to interpose this procedure before the child is admitted seems that it will afford more alternatives in case the child's position is upheld. It will decrease the amount of alienation, and those 48 hours are more in which the child has to stew and will afford the opportunity for a reconciliation if that is going to be the fact—I mean after all, if we say that there is going to be a judicial hearing and we recognize the fact that the child in fact may be upheld in his request, it is not inevitable that they are going to agree—I would assume that all of the recommendations are to be adhered to.

Q. But doctor, that assumes that when a juvenile is evaluated through the base service unit and implementation of (55) any programs as to occur, it doesn't occur until after institutionalization and that isn't necessarily so?

A. I don't understand that.

Q. In other words when a person is being evaluated, either in New York—I'm sure through your county health mental retardation units or in Pennsylvania, I would assume that psychiatrists, when they see that the problem exists are going to establish procedures to help the juvenile—they are not just going to sit by and not help them?

A. Yes, I think that is probably true, but I think we can't presuppose that amount of good will all of the time when we are dealing with somebody's rights, and I would assume that during this time the psychiatrist would be attempting to establish a rapport with this client, to perhaps do some persuasion to feed back observations, to make recommendations, and so on and even if that isn't—and if that isn't taken up by the child, I think the child should still have resource to other avenues before he is hospitalized.

Q. Well, what about the fact that when the child is hospitalized, that treatment begins when he becomes hospitalized?

A. What treatment are you talking about?

MR. FERLEGER: Objection.

MR. ROTH: I am talking about the fact that (56) recommendation and treatment plans that have been initiated prior to his institutionalization have occurred and the treatment program continues.

MR. FERLEGER: Objection, that question must be objected to on the basis of Mr. Roth is testifying about some treatment plans that are established for some unknown patients. That is not part of the record in this case.

If Mr. Roth wants to ask the doctor about his experience as director of his mental health center, then he can testify about whether or treatment takes place there, but you certainly can't testify and Mr. Roth can't testify about some alleged treatment in Pennsylvania.



BY MR. ROTH:

Q. Now Doctor, you have testified that rather than having someone stew for 48 hours—and I am merely advising you that that is not necessarily the case, and I am saying if in fact a person does receive treatment, continuous treatment, aren't those needs of the person met?

A. Mr. Roth, I'd like to correct a misconception I think you are implying, that is a person does not receive treatment, a treatment is a collaborative effort, and a person does not have treatment poured into him. Psychiatric treatment is a long arduous affair which involves the development of a (57) relationship of trust, and it cannot be done in a coercive way, so when you say "treatment," I question what in fact you mean.

Q. Well, when I say "treatment," of course not being a psychiatrist I am saying that some plan has been established by a psychiatrist that of evaluating the juvenile prior to as well as at admission, and that that plan, whatever it be is continuing, and I am saying assuming that were to occur, how—why do you feel, then that a hearing subsequent thereto, if necessary could not be held?

A. Because I question the possibility of treatment occurring under those circumstances, and I question the possibility that we are not, by enforcing this coercive situation, ruling out this patient for any subsequent treatment, at any opportunity in the future to voluntarily seek help from a mental health facility. My feeling is that this experience is more likely than not to be a negative one.

Q. Doctor, are you ever aware of situations where, because of reliance upon a judicial system, whether it be for an emergency hearing—no, I am sorry, whether it be for an emergency or non-emergency that the judicial process has been slowed to the extent that the person has com-

mitted suicide because they weren't able to get into the institution right (58) away?

A. Well, I—

MR. FERLEGER: I don't see how that is relevant. That procedure is for children. When we have judicial proceedings in Pennsylvania for adults, and if Mr. Roth is suggesting that adults be treated as children in Pennsylvania, that question is irrelevant.

MR. ROTH: Notwithstanding Mr. Ferleger's gratuitous remarks—

THE WITNESS: I would like to add, if you are hypothesizing an emergency situation, that isn't the statute under question.

MR. ROTH: I am not asking you about this statute under question, I am asking you in your professional opinion, or in your knowledge, have you ever heard of situations where a person perhaps died with their rights on?

MR. FERLEGER: Could you lower your voice, Mr. Roth? You are yelling.

MR. ROTH: Mr. Ferleger, I am sorry, I am not yelling and I am sorry you are so sensitive that you can't listen.

THE WITNESS: I am amazed that that—at your hypotheses, but I won't question that, but I have not (59) heard of such a case, quite frankly.

MR. FERLEGER: Mr. Roth—

MR. ROTH: Mr. Ferleger, I would like to continue with the examination.



MR. FERLEGER: Your questions are becoming a bit redundant and far afield from the case. Dr. Feiner has to leave in about two minutes in order to make a train, and if you have any relevant questions to ask, I wish you'd ask them now so that the deposition can be concluded.

MR. ROTH: Mr. Ferleger, with all due respect, I have many more questions to ask of Dr. Feiner.

With regard to that, the Notice of Deposition says "Is expected to be completed within two hours." Subsequent to that time, we had correspondence with our own staff indicating that we may need additional time, and there was no objection to that.

MR. FERLEGER: If we need additional time for relevant questions, I have no problem with that.

MR. ROTH: Well, I think the Court can very well determine what questions are relevant and irrelevant.

MR. FERLEGER: You are asking irrelevant questions. They don't seem to me to be appropriated if we can't conclude by the time that Dr. Feiner has to make his (60) train, then we will be glad to continue it to another day.

MR. ROTH: Well, I have numerous questions for you, Dr. Feiner.

BY MR. ROTH:

Q. Dr. Feiner, do you feel that there are differences between juveniles and adults in terms of their self-awareness regarding use of institutions, of they needed to?

A. No.

Q. In other words you read Dr. Sugar's deposition and he felt that youngsters have a lot of hormonal changes, secondary changes, growth changes—he felt that these do not become complete at the late adolescent years, and he felt that there was very much a distinction between adults and juveniles in terms of development?

A. Well, you didn't ask me that question. Of course there are. You asked me regarding the use of institutions, and I suggested—

Q. In regards to their awareness, I am sorry?

A. In regards to their awareness, I think they are individualized, and I wouldn't be prepared to make a generalization. I have seen numerous adults who were not prepared to take advantage of the institutions available to them in this society.

(61) Q. Well, one of the thrusts of this lawsuit is to have sections under the act declared unconstitutional which treat juveniles differently from adults. Is that your understanding?

A. Yes.

Q. And there is a possibility that if that were so done, that juveniles would be afforded the same rights as adults to admit and release themselves?

A. That's correct.

Q. Now, do you feel a child aged 5 would have any capacity at all to even make that determination whereas an adult aged 19—where are the differences?

A. Obviously there are significant differences, but if—I can foresee a child with an Advocate participating in a situation in which the child is realized into another situation or home.



Q. Do you think it is feasible that that occur, if—you know—for juveniles to admit and release themselves as adults do in Pennsylvania?

A. Do I think it is feasible?

Q. In your professional opinion?

A. I would not be here if I did not think it was feasible.

Q. How would a 3 year old even approach that?

MR. FERLEGER: Mr. Roth, your questions—(62) and I am waiting for you to ask about the 3½ and 4½ and the 4 and ¾ year old—your questions are just prolonging this deposition in a ridiculous manner. Obviously—and your own Dr. Sugar testified that 13, 14, 15, 16 and 17 year old kids could go in and out of institutions. We are not talking about—

MR. ROTH: Do you have an objection?

MR. FERLEGER: For younger children—

MR. ROTH: Are you testifying or do you want to object?

MR. FERLEGER: This is my objection, Mr. Roth, for younger children as the doctor testified, an Advocate is the one who would be speaking to the court, not the 3 year old and for a 17 year old severely retarded person it would be an Advocate or a guardian ad litem. Your questions are just absurd.

BY MR. ROTH:

Q. The question still remains, Doctor, in terms of the procedures which plaintiffs seek.

A. I cannot foresee that possibility of the child speaking for himself, but should the possibility ever come up, I would think that those rights would extend—I mean

—it is certainly unlikely, if not impossible that that would occur (63) with a 3 or 5 year old, but where are you going to draw the line? There are certainly some sophisticated 9 and 10 year olds, just as there are some very naive 30 and 40 year olds.

Q. Well, do juveniles who need hospitalization necessarily recognize it?

A. I think that juveniles need hospitalization on occasion, and often do recognize it. I think that adults who need hospitalization often do not recognize it, also.

Q. I am asking about juveniles. Do you have juveniles that tend to avoid reflection and introspection?

A. Juveniles may make their needs known through behavior.

Q. Let me ask you this.

Is it your testimony in part that you feel parents really do not operate in context of this situation for the well-being of their children?

A. No.

Q. Do you feel by and large parents do?

A. I think it is a very mixed bag. I am suggesting where there are enough indications where they don't require some protection, and I hope to work in a situation where we see numerous cases of child abuse and neglect—I am quite sensitized to that possibility. We are not talking about one case.

(64) Q. Have you ever admitted a child to an institution?

A. Yes, I have.

Q. To which institution?

A. I have admitted a child to Bronx Municipal Hospital Center.

Q. Were you the admitting physician?



A. Yes.

Q. And how did that occur?

A. That occurred by my following the procedures that were available to me at that time and operating under the guide lines which the institution functioned. I have since been able to participate in changing that situation to make it more flexible, and to decrease the possibility of a child being admitted under those circumstances.

Q. Do you admit many children to institutions?

A. No. I have not admitted a child to an institution personally in some time.

Q. Are you opposed to institutions?

A. Absolutely not. Absolutely not. I am not talking against admitting children to institutions, I think they serve useful functions, serve a useful function when used appropriately. I will mention another alternative which is being used as well, and that is day treatment centers where children spend their days in a community setting living at home.

(65) Just to add another alternative to the family of psychiatrists.

Q. When a juvenile comes to your facility, how long a process occurs in terms of making a recommendation of whether or not the juvenile needs an alternative type of care?

A. What procedure usually occurs?

MR. FERLEGER: That has already been testified to, Mr. Roth.

THE WITNESS: It has been testified to.

We will gather as much information as we can, and as many contexts as we can involving as many people who can provide information and opinions.

BY MR. ROTH:

Q. In the clinic where you work, how many psychiatrists are there and how many patients come in daily?

MR. FERLEGER: Objection, Mr. Roth. Dr. Feiner has to leave in—as a matter of fact right now for a train. If you have relevant questions, I wish you'd ask them quickly so we can conclude the deposition today rather than continuing it. If you want to submit Interrogatories, if you have any relevant questions left, that is fine, but the number of patients at his institution is irrelevant.

BY MR. ROTH:

(66) Q. How many patients come into your facility daily?

A. Maybe 50. I—you know, I really have to leave. I have an important and professional commitment in New York.

Q. Dr. Feiner, I have still several questions.

Do you often testify?

A. No, not often at all.

Q. How many times have you testified in the past year?

A. None.

Q. In the past 3 years?

A. Once or twice.

Q. Are you being compensated for your testimony?

A. No, I am not.

Q. In your opinion, if a methodology of treatment occurred once the juvenile was seen by whomever in terms of psychiatric evaluation, if a treatment plan were established at that point, and if there were any alteration of that treatment plan in terms of either having the patient be seen at a facility many times a week or having the patient institutionalized or anything of that sort, do you think at that point a judicial hearing should occur?



A. I think a judicial hearing should be available to a person at any time they chose to request it, and I think that it is the mental health person's legitimate responsibility (67) to explore that request, but when—I don't think he can do more than explore it, and under its meaning and the reason for it occurring at that particular point.

Q. What would happen if—if you started a treatment program for a juvenile and the juvenile objected to that treatment program, do you think a hearing should be afforded at that time and that the treatment program should stop?

A. No. I think the juvenile would—I would try to persuade, I'd try to prescribe, and if the juvenile then chose not to participate in treatment, despite all of the technical maneuvers available to me, I would not be able to treat that person, nor would I want to coerce them into treatment, because I would think that I would lose them for the possibility of treatment forever.

There are often occasions where juveniles will want a taste treatment, a little bit to see what it is like when they are brought there—they want to see who is this doctor, what is it all about, and then they will leave, because they want to come in on their own, and I have seen this happen a number of times where a juvenile has terminated treatment orally; they have said "Fine." They have gone out, they have done what they have had to do and they have come back on their own and treatment has really begun at that point.

(68) Q. But the question still remains, you feel if a juvenile objects to any point and wants a judicial hearing, that a judicial hearing should occur; is that correct?

A. Are you talking about a juvenile in a hospital?

Q. No, I am talking about when you establish a plan, if the juvenile doesn't want to participate in the plan—

A. Oh, if I am an outpatient therapist for this juvenile, I regard that completely as a voluntary contract. We use the term "contract" not in your terms, but we have established very early an understanding between us that this is completely voluntary; that it is completely confidential and at any time either one of us feels that things aren't working out and I reserve that right myself, to say that this is a situation that I don't think I can deal with, I reserve—we each reserve the right to terminate that relationship.

Q. But with regard to the question itself, if, in the best interests, in your professional opinion as a psychiatrist you feel that the juvenile should be treated, either on an outpatient basis or any other basis and the juvenile objects at that time, you feel that a hearing should be afforded the juvenile?

MR. FERLEGER: He testified—

MR. ROTH: He didn't answer the question.

(69) MR. FERLEGER: —that that implies the institutionalization, not outpatient treatment.

THE WITNESS: I have never heard of a situation—

MR. ROTH: I am not asking you what you have heard, I am asking you your professional opinion, Doctor.

MR. FERLEGER: Well, an opinion about something that doesn't happen is sort of useless.



THE WITNESS: I would have serious feelings that if a court determined the juvenile had to stay in treatment that anything useful could be accomplished under those circumstances.

BY MR. ROTH:

Q. Well, don't you feel that juveniles could be negative to admissions anywhere to institutions or day care programs but nonetheless be still co-operative in the treatment program itself?

A. Well, maybe. Maybe. Maybe a certain percentage are, but not certainly not a hundred percent.

Q. Do you find that juveniles—just by the mere chronological age are recalcitrant and as a result object to any type of methodology?

A. Oh, no, I find that recalcitrant is part of the program (70) and part of the give and take that people deal with kids have to learn to understand.

Q. Yes, but as that being part of the charm, isn't that part of the effect of objecting to anything?

A. It is not for me to coerce. I am a service employer. I am a therapist.

Q. Based on your experience, don't you find that juveniles generally object to confinement of any sort?

MR. FERLEGER: Most adults, I know object to confinement of any sort.

MR. ROTH: I am sorry, I am asking the question to Dr. Feiner.

THE WITNESS: That is the kind of idea I was trying to phrase. I think that we have due process situations, because most human beings object to confinement. If you will excuse me, I really have to go.

MR. ROTH: Well, I still have many questions.

MR. FERLEGER: How many questions?

MR. ROTH: Several.

MR. FERLEGER: Three?

MR. ROTH: Several.

MR. FERLEGER: Is several three or twenty?

MR. ROTH: It would also depend upon (71) Dr. Feiner's responses.

MR. FERLEGER: Well, at this point do you have three or twenty?

MR. ROTH: I have several.

MR. FERLEGER: Well then, we will have to conclude the deposition.

Would you like to continue the deposition to another date?

MR. ROTH: I would like to finish.

MR. FERLEGER: Or one more minute or so, if you have several we can get them done.

MR. ROTH: Mr. Ferleger, it is a shame that when you sent out the notice you said it was going to be at least two hours, and then in contact with your own staff members, if asked if we could go beyond that because we knew we would need time, we were assured of that.

MR. FERLEGER: At that point, we didn't know that Dr. Feiner had another commitment at 5:00, and we have, of course the same problem that



we had when you wanted the deposition of Dr. Sugar restricted, because he had to go give a speech and I cooperated at that point, and we finished the deposition in time for him to make the speech.

MR. ROTH: Oh, Mr. Ferleger, you showed up (72) 45 minutes late. How can you say you cooperated?

Dr. Feiner, let me ask you this, now, you have testified on direct examination that you think confinement to a general hospital is different, for example you brought up the illustration about someone who is affected with tuberculosis would be different than a mental illness, if you will. Why don't you think a hearing, prior to admission of a general hospital should occur?

THE WITNESS: As far as I know, I mean I can't be specific about the law, but I think that there are probably Jehovah's Witnesses who do avail themselves of those opportunities.

BY MR. ROTH:

Q. Well, I am asking you, though, in confinement of any person to an institution, be it a general hospital or a state institution, don't you think—you know—for a juvenile that a due process hearing should occur?

A. I am looking—

Q. Go ahead.

A. I think that there is some substantial differences between a physical illness and emotional difficulties.

Q. Don't you think parents, as you testified could misutilize a situation and put their juvenile, their child into a general (73) hospital?

A. Oh, sure, sure, and may be there should be due process.

MR. FERLEGER: Do you have further questions, Mr. Roth?

MR. ROTH: Yes.

MR. FERLEGER: Okay, the deposition will be continued to a date that I will notify you of, Mr. Roth.

Thank you, Dr. Feiner.

MR. ROTH: You can show on the record that I object to the continuation of the deposition on the basis that I was assured that I would be able to fully cross-examine the witness. I have not completed my cross-examination of the witness; that I was told the deposition would occur for at least two hours and more, and in subsequent conversation with Mr. Ferleger's staff and confirmation in writing of the same—

MR. FERLEGER: We have no problem with the deposition being finished, so that Mr. Roth will be able to finish his questions, and that is the very reason why we have continued the deposition, so that all parties can have the benefit of Dr. Feiner's testimony.

MR. ROTH: Well, I question the whole deposition in terms of Mr. Ferleger's misleading an unfair and inappropriate statements regarding the length of the deposition.

(74) (Whereupon at 3:18 the deposition was adjourned.)



File L

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

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Civil Action Number 72-2272

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Kevin Bartley, et al.,
Plaintiffs

v.

Haverford State Hospital, et al.,
Defendants

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ORDER

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AND NOW, this 21st day of August, 1974, after consideration of the parties' proposed Final Pre-Hearing Order and after a conference in chambers on July 30, 1974 regarding said order, it is hereby ORDERED:

1. Final hearing and argument herein shall take place on September 9, 1974 beginning at 10:00 A.M. in a courtroom to be designated, and on September 11 from 9:30 A.M. to 1 P.M.

2. Pre-trial briefs are not required. Any briefs which the parties may wish to submit must be filed on or before September 3, 1974.

3. The parties' Final Pre-Hearing Order, filed including their stipulation of facts and other matters, is

fully approved and adopted by the Court together with the following amendments and additions. References are to the pages and paragraphs of said order.

a. Defendants shall be permitted to call as witnesses Dr. Derek Miller of the University of Michigan and Dr. James Masterson of the Cornell Hospital in New York.

b. The "Discharge and Readmission Data" (Page 10, Par. 3) shall not be admitted.

c. The question of monetary liability of Defendants shall be briefed if and when it becomes an issue herein (Page 10, Par. 4).

d. Paragraphs 1 through 8 at pages 14 through 18 are admitted and included in the factual stipulation. Defendants shall be permitted to comment on and to make a statement on these facts. Defendants may prepare an exhibit by September 2, to be approved for accuracy and completeness by Plaintiffs, regarding the admission of the following patients' cases listed on pages 14 and 15 (noted here by institutional number):

Pennhurst #402
Polk #13,173
Polk #13,077
Western #281
Western #288
Polk #13,212
Western #144
Western #15
Western #67
Western #131



In their review of patient records for the purpose of preparing this exhibit, the parties shall protect the confidentiality of the patients' records.

e. The Plaintiffs' witnesses are as indicated at page 19 of the aforesaid order. The Defendants' witnesses are:

Dr. Derek Miller
University of Michigan
Ann Arbor 48104

Levon Tashians, M.D.
Institute of Pennsylvania Hospital
111 North 49th Street
Philadelphia, Pa. 19139

Barbarba Armstrong, M.D.
Haverford State Hospital
3500 Darby Road
Haverford, Pa. 19041

Dr. James Masterson
60 Sutton Place South
New York, N.Y.

James Gibbs, M.D.
Director of Child and Adolescent Psychiatry
Sheppard-Pratt Hospital
Baltimore, Md. 21215

Both parties agree not to contact the witnesses without approval and presence of opposing counsel.

f. Plaintiffs' Exhibits 2 and 3 may be offered at the hearing (page 21) and the Court will determine their admissibility and weight.

g. Plaintiffs may take the deposition of Dr. Joel Finer in Philadelphia, Pa. which deposition may be admitted as a trial deposition.

h. Plaintiffs shall submit three copies of Dr. Barbara Armstrong's deposition to the Court with those portions to be admitted underlined in red. All portions on which the parties disagree shall be admitted.

i. The deposition of Dr. Max Sugar may be admitted as a trial deposition.

j. The submitting parties shall give the other parties notice of the contents of their summaries as early as possible.

By the Court:

(s) Daniel H. Huyett, 3d
Daniel H. Huyett, 3d

Dated: 8/21/74



IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

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Civil Action No. 72-2272

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[Title omitted in printing.]

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EVIDENTIARY HEARING

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**First Day**

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Philadelphia, Pa., September 9, 1974
(10:00 a.m.)

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**Before:**

Hon. John J. Gibbons, C. J.
Hon. Daniel H. Huyett, 3rd, J.
Hon. Raymond J. Broderick, J.

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**Present:**

David Ferleger, Esq., Attorney for Plaintiffs, Mental Patient Civil Liberties Project, Philadelphia, Pa. 19107.

Barry Roth, Esq., Assistant Attorney General, Darius G. C. Moss, Esq., Assistant Attorney General, Attorneys for Defendants, Office of Legal Counsel, Department of Public Welfare, Harrisburg, Pa. 17120.

(2) (All Counsel and parties being present, the following transpired in open court.)

JUDGE GIBBONS: Mr. Roth, the first item of business I suppose is your motion to dismiss, and I should advise you we have concluded we will take that under advisement and you should proceed with the testimony.

MR. ROTH: Thank you.

MR. FERLEGER: Just for the record, your Honor, I think you have forgotten that I think that was already taken care of in a previous order.

JUDGE GIBBONS: I think it may have been, but I see it is listed.

MR. FERLEGER: I wasn't aware of that.

JUDGE HUYETT: How did we take care of it in the previous order?

MR. FERLEGER: In your April 29th order after our meeting, you asked me to draft the order which allowed the case to be maintained as a Class Action, dropped Haverford Hospital as a Defendant, appointed myself as guardian and denied the motion to dismiss.

JUDGE GIBBONS: Well, it is listed this morning. Whether that is a renewal or otherwise, we will take it under advisement.

Mr. Ferleger, do you have a witness?

(3) MR. FERLEGER: Yes, your Honor.

This morning we have three witnesses to present to the Court, all expert psychiatrists.

The first is Dr. Henry Kandler. He will testify regarding his experiences as a psychiatrist and working with lawyers.



Our other two witnesses will follow.

To save time, rather than making any statement, I'd like to call Dr. Henry Kandler to the stand.

MR. ROTH: Your Honor, if I may, I would like to make some specific requests of this Court and I'd like to do that now if that would be appropriate with regard to—

JUDGE GIBBONS: We cannot tell whether it would be, until we hear the requests.

MR. ROTH: May I be given the opportunity to present them now?

JUDGE GIBBONS: Yes.

MR. ROTH: Thank you, your Honor.

I appropriate this time, your Honor, to present several matters before your Court.

The first being through an oversight, I was under the impression that I had submitted the admission notes of Alan Moss and Donn Dickel. The opposing counsel (4) had submitted affidavits by these two youngsters who are at the Haverford State Hospital and I had spoken to Judge Huyett through his law clerk, Mr. John Langel indicating I would like to introduce into the record the admission notes of those two juveniles.

I am prepared to have Dr. Kratsa, who was the admitting psychiatrist, testify to these admission notes.

I am also prepared to have affidavits submitted by him which I have now. I sent a letter to your Honorable Court on September 3rd, indicating the admission notes of these two youngsters.

I know this has not yet been introduced into evidence by opposing counsel. However, I would like to reserve

that right to introduce these notes in order to further elucidate the position by the Defendants in this case.

JUDGE GIBBONS: Do you have any objection?

MR. FERLEGER: Yes, I do, your Honor.

These affidavits of the Plaintiffs were filed on April 25, 1973, under an order—special order protecting the confidentiality and the rights of the affiants.

Mr. Roth, not only knew about it since 1973, but never mentioned any desire to submit any (5) counter affidavits, either in the pretrial order negotiations or in our meetings with Judge Huyett. I think that once the final prehearing order has been entered that it is improper to suddenly on the day of trial or week before it, to decide that you want to submit counter affidavits.

JUDGE GIBBONS: Do you have any substantive objection?

MR FERLEGER: No. I am sure that the copies of the admission notes that Mr. Roth has are accurate copies.

JUDGE GIBBONS: You may do that and you can have them marked with the clerk and sometime before it is necessary to make reference to them.

MR. ROTH: Fine. I shall admit them now.

We will not be making reference to them in the hearing, your Honor.

JUDGE GIBBONS: We won't take the time. But I charge you with the responsibility of getting them appropriately marked in evidence before it is necessary to make reference to them.

MR. ROTH: Thank you.



I do have several other matters and again, I appreciate your indulgence.

With regard to our regulations which were (6) promulgated and adopted back in September, 1973, we had a hearing in April and I had indicated to the Court at that time how those regulations were being affectuated [sic] and in particular, I indicated a compilation of statistics compiled by Mr. Ralph Phelps of the Office of Mental Health in order to show the Court what was happening in each instance where juveniles objected to subsequent admission.

At that time it was my impression it had been introduced into the record and in order to insure that, I would prefer to introduce that also before your Honor. Again, I had alerted this situation to his Honor Judge Huyett through Mr. Langel last week and I am prepared to have Mr. Phelps come down from Harrisburg in order to testify to his compilation of these statistics.

JUDGE GIBBONS: Mr. Ferleger?

MR. FERLEGER: Your Honor, with reference to that, that was discussed as Mr. Roth indicates and I noted at that time that I had two clients who had objected to institutionalization who weren't listed on that summary so it was clear to me that factually that summary was incorrect with regard to at least two of my clients and I imagine with regard to other people across the state.

It purported to be a summary of all cases across the state in which these new regulations had been (7) involved and I don't see how, especially with non-state hospitals and I know for a fact that two cases are not listed on there, I don't see how this can be introduced into evidence at

all and I really don't see the relevance of it to this Court's proceedings.

MR. ROTH: Your Honors, if I may?

JUDGE GIBBONS: I think he would be entitled to cross-examine. The summary could go in if you had a witness here that he could cross-examine. I don't think it could, otherwise.

MR. ROTH: With regard to Mr. Ferleger's comment, the number of objections had not been listed by individual name. It just had been listed as to the number of objections and how the institutions handled those objections at the time.

JUDGE GIBBONS: I think you had better produce the witness and lay the groundwork for the introduction of the summary, so that Mr. Ferleger can cross-examine and object.

JUDGE BRODERICK: May I suggest something?

JUDGE GIBBONS: Yes.

JUDGE BRODERICK: May I suggest if the summary is corrected there could be an agreement to it, but otherwise, as Judge Gibbons has just indicated you will have to follow that procedure.

(8) MR. ROTH: Thank you, your Honor.

With regard to the prehearing order, we did agree that the Commonwealth would supply the admission profiles, if you will, of ten patients selected by the plaintiffs. I had sent these patients' profiles on to this Honorable Court and to Mr. Ferleger sometime ago and we would like to introduce those into evidence, also.



I have not heard of any objections prior to this time from opposing Counsel with regard to those ten patients' profiles.

JUDGE GIBBONS: Mr. Ferleger?

MR. FERLEGER: I have no objection.

JUDGE GIBBONS: They will be marked in evidence and again, rather than delay the witnesses, I charge you with the responsibility of having them appropriately marked before they need to be referred to.

MR. ROTH: Thank you, your Honor.

Again, thank you for this time.

With regard to our witnesses, your Honor, we had five witnesses and we have narrowed that to four witnesses. We have excluded Dr. Armstrong.

Now, it has been my review of the situation with these witnesses that each witness will take approximately an hour to an hour and a half. Today, we are going to begin with Dr. Tashjian. On Wednesday, we anticipate (9) calling Drs. Masterson, Miller and Gibbs.

Now, with regard to the time limit on Wednesday which will be from 9:30 to 1:00 o'clock, pursuant to your Court order, it would be appreciated if we could continue this for another day—to present Dr. Gibbs.

All these gentlemen are from out of state, Michigan, New York, Baltimore. I am prepared to have Dr. Gibbs come on Wednesday if you so desire. I have alerted Judge Huyett through his law clerk, to this situation.

JUDGE GIBBONS: I think we will have to anticipate only getting through two on Wednesday. Our collec-

tive judgment is that by the time cross-examination is finished, it will be so close to one o'clock as to make it impossible to complete the third doctor and we don't think it is appropriate to have him make two trips.

Therefore, you can assume that we will continue with his testimony on a subsequent date and that closing argument will be held on that same date.

MR. ROTH: Thank you, your Honor.

JUDGE GIBBONS: Monday, October 7, 1974, we will convene at ten o'clock and complete the testimony. Any rebuttal testimony should be presented at that time and we will proceed with closing argument. If need be, (10) we will continue on the 8th of October. We will advise you of the courtroom.

MR. FERLEGER: Thank you, your Honor.

MR. ROTH: Thank you, your Honors.

Your Honors, with regard to the pretrial deposition of Dr. Max Sugar, that deposition I would like to introduce into the record, also.

Now, I have provided the Court with a rather lengthy summary of that deposition some time ago and last week, I did receive the signed copy—the signed original— of Dr. Sugar's deposition by him and I had advised him, you know, pursuant to Court Rule 30, that he ought to state in an accompanying letter any objections that he had to form and substance.

Dr. Sugar merely changed some words around on the original deposition. He has supplied me with that, but not provided me with reasons. I can assure this Honorable



Court, as well as Mr. Ferleger, that there has been no changes as to substance.

Nonetheless, I'd like to introduce that pretrial deposition, as well as the changes on xerox sheets which I have, and reserve it for Mr. Ferleger's objections.

JUDGE GIBBONS: Mr. Ferleger, any objections to that course?

(11) MR. FERLEGER: No, I haven't seen the corrections and I'd like to.

I might note, just for the record, that Dr. Finer, who was deposed by the court order in this case, I'm still waiting for the court reporter's transcript, because we did not have time for Mr. Roth to finish his questions and he has agreed to submit interrogatories and we hope that will be done by October the 7th.

MR. ROTH: That was my next point.

Hopefully, I will have that done by October 7th. In any event, I will have that certainly done before the record is closed in this case.

With regard to Dr. Armstrong's deposition which was taken, I believe, in March of 1973, your Honors, we have agreed that Mr. Ferleger would underline portions agreed upon and those portions disagreed upon would be admitted into evidence.

I have not yet received that, although I have received several papers from Mr. Ferleger just a few minutes ago and I believe one of those papers does refer to the deposition of Dr. Armstrong. I haven't had a chance to read any of these. However, I just wanted to indicate to the Court that I am agreeable to submitting the deposition of Dr. Armstrong in its entirety, if necessary.

(12) JUDGE GIBBONS: All right. Again, I charge you to have it appropriately marked. All of these depositions have to be marked in evidence.

MR. ROTH: Fine.

Your Honor, I believe Mr. Ferleger will be introducing that deposition in accordance with our agreement.

JUDGE GIBBONS: If it is your offer, you, Mr. Ferleger, are responsible to having it marked in evidence.

MR. FERLEGER: Certainly, your Honor.

MR. ROTH: With regard to my understanding of what is in the record, specifically, we are requesting that all the interrogatories and answers are in the record and especially the answers to—

JUDGE GIBBONS: Have they been marked in evidence?

JUDGE HUYETT: They have not been marked.

MR. ROTH: No, they haven't. I believe we discussed that at the prehearing conference and I believe we decided they would all be introduced into the record.

MR. FERLEGER: There was no decision to abandon marking them.

JUDGE GIBBONS: They should be marked, (13) because they are not in the record for appeal purposes, unless they have been admitted into evidence.

JUDGE HUYETT: I would suggest that Counsel get together before October 7th and give them the next exhibit numbers so they are marked and then they can be formally admitted into the record. Just because something



has been docketed and filed, does not make it part of the record for appeal purposes.

MR. ROTH: Thank you, your Honor, we shall do so.

Again, I had spoken to Judge Huyett through Mr. Langel last week, regarding the submitting the biographies of the expert witnesses and perhaps we can arrive at a stipulation with regard to that.

Neither Mr. Ferleger nor I have exchanged the Curriculum Vitaes of the witnesses and it would be my feeling at this point, your Honor, although I'd like to expedite the hearing that perhaps we should hear the qualifications and if your Honors feel we should submit the biographies, we will, but I think it is necessary to hear the qualifications.

JUDGE HUYETT: Are these fairly short?

MR. FERLEGER: Just to let you know what the plaintiffs are doing. You have, I handed up this morning before you arrived, Plaintiff's Exhibit Numbers (14) 1, 2, and 3. Number 1, the Court has already ordered, it may be admitted. Numbers 2 and 3, the Court has given us permission to submit them here this morning.

Dr. Leon Ginsburg, as I explained to Judge Huyett in a paper filed, he is in South America. The affidavit has been filed for more than a year, I believe, although Mr. Roth has told me that he did not get it when we originally sent it out.

Exhibits 4, 5, and 6, are the resumes of our expert witnesses and I would move, maybe to expedite things, for the admission of all of our Exhibits at this time.

JUDGE GIBBONS: Move the admission of each Curriculum Vitae as the witness is on the stand, so it appears in the same part of the record.

JUDGE HUYETT: Are they too long to read?

My thought is to save time and if the Curriculum Vitae is short it could be read and this would be supplemented by a few questions, rather than going through a long procedure of questions and answers.

MR. FERLEGER: What I was anticipating was having my witnesses describe the most salient points of their qualifications and leave a lot of the listings of articles and talks to the written material.

JUDGE GIBBONS: Just mark the Curriculum (15) Vitae as each witness gets on the stand and present those highlights that you think are appropriate by question.

MR. FERLEGER: I will, your Honor.

JUDGE GIBBONS: Anything else, Mr. Roth?

MR. ROTH: Yes, your Honor.

With regard to my brief which was submitted about two weeks ago, I would just like to note a correction on page 22 and it appeared that the citation of Logan versus Arafeh, that should be Volume 346, your Honor. I'm sorry for that.

Your Honor at this time, that is all I have. Thank you again.

MR. FERLEGER: Dr. Kandler.



HENRY O. KANDLER, sworn.

THE CLERK: Would you state your full name?

THE WITNESS: Dr. Henry O. Kandler.

*Direct Examination*

BY MR. FERLEGER:

Q. What is your address?

A. My office is 124 East 84th Street in New York City.

Q. What is your occupation?

A. I am a psychiatrist.

Q. Would you please give to the Court briefly your (16) current affiliations or appointments?

A. Yes.

I am Assistant Clinical Professor of Psychiatry at the Albert Einstein College of Medicine and I am Associate Attending Psychiatrist at the Bronx Municipal Hospital Center.

Q. Have you been associated with any hospitals in the state hospital system?

A. Yes; for a period of five years I was Supervising Psychiatrist at Bronx State Hospital.

Q. What are your current responsibilities at the Albert Einstein College of Medicine?

A. Right now I am Associate Director of Adolescent Psychiatry at both the medical school and hospital.

Q. What do you do in that capacity?

A. Primarily, I supervise trainees, fellows and residents who work in the clinic right now and I am also in charge of the school consultation program and have some administrative duties as far as the clinic is concerned.

Q. For how long have you been involved in the area of child psychiatry or adolescent psychiatry?

A. For 16 years.

This clinic job is a new one for me. For the past 16 years, I have been involved in in-patient psychiatry.

(17) Q. What facilities?

A. At the same facilities that I have mentioned.

Q. Can you estimate the number of children involved that were under your responsibility or supervision?

A. We admit somewhere between 60 and 100 adolescents a year, depending on how those services were set up.

I was usually, during this period of time, in charge of one ward. So that would be about one-third of them. So, I estimate that I have been in perhaps direct charge of 400 adolescents who have been admitted to our hospital.

Q. Do you work with children or families of children in your private practice?

A. Adolescents, yes. Not younger children.

Q. Dr. Kandler, you have seen the Curriculum Vitae that you gave me and it is now in the Court's hands.

Is that an accurate summary of your qualifications and background?

A. Yes.

MR. FERLEGER: Your Honors, I'd like to move for the admission of Plaintiff's Exhibit Number 4.

JUDGE GIBBONS: Number them in sequence as to whatever the next plaintiff's number is.

JUDGE HUYETT: Were your Exhibits 1, 2, and 3 admitted at the prehearing conference?



(18) MR. FERLEGER: Yes. Exhibits 2 and 3, your Honors ordered we'd be allowed to submit for a ruling today.

JUDGE HUYETT: Where are Exhibits 1, 2, and 3, physically? Have they been marked?

MR. FERLEGER: Exhibit 1 has already been docketed and filed. Exhibit 3 has already been docketed and filed and Exhibit 2 has been docketed and filed, as well.

MR. ROTH: If I may, your Honor, as I recall the Exhibits were disagreed upon in our statement of facts and it is up to the Court in order to determine the probative value today.

MR. FERLEGER: Except for Number 1. Number 1, Judge Huyett ordered admitted.

JUDGE HUYETT: Where is there a reference to these in the prehearing order?

MR. FERLEGER: In your order issued after our last conference, at paragraph 3(f), your Honor ordered that plaintiff's Exhibits 2 and 3 may be offered at the hearing and the Court will determine their admissibility and weight.

MR. ROTH: Exactly. In that order, it does not say anything about Exhibit 1. It was my understanding that this Exhibit was not admitted.

(19) JUDGE GIBBONS: Let's not talk about Exhibit 1 at this point. Let's get a number for what you referred to as "Exhibit 4."

The previous Exhibits have been given numbers 1, 2, and 3 in the prehearing order and this will be

marked Exhibit 4 which will be admitted in evidence.

Give the Clerk a copy for the Court to file.

(Whereupon, the Curriculum Vitae of Dr. Kandler was marked Plaintiff's Exhibit 4 in evidence as of this date.)

MR. ROTH: I do have some questions with regard to the witness' qualifications.

JUDGE GIBBONS: You may examine now on his qualifications.

MR. ROTH: Thank you, your Honor.

MR. FERLEGER: Your Honor, if Mr. Roth is just going to question with regard to the extent or stature of his qualifications, I think he should hold that for cross-examination, but if he wants to question—

JUDGE GIBBONS: He may examine on his qualifications at this point.

MR. FERLEGER: Thank you, your Honor.

MR. ROTH: Thank you.

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(20) *Cross-Examination*

BY MR. ROTH:

Q. Dr. Kandler, would you please indicate to me if you are Board certified in general psychiatry?

A. No, I am not.

Q. Are you Board certified in child psychiatry?

A. No, I am not.



Q. Are you Board eligible in general psychiatry?

A. Yes.

Q. Are you Board eligible in child psychiatry?

A. I am not sure—I think you have to have the general first.

Q. Can you please explain the difference between Board eligibility and Board certification?

A. The difference is taking an examination and passing it.

Q. Is it not true, Doctor, that Board certification indicates an acceptable level of expertise in that area of psychiatry?

A. I personally don't believe so.

Q. Does not that Board certification indicate what I just revealed to you?

A. I don't believe so, no.

MR. ROTH: Your Honor, at this time, I will reserve questions with regard to his experience (21) and history in general and child psychiatry for cross-examination.

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*Continued Direct Examination*

BY MR. FERLEGER:

Q. Dr. Kandler, as you know, this lawsuit involves the rights of children to have pre-mental commitment judicial hearings. That involves the relationship between the law and psychiatry.

Have you had any experience with lawyers being involved in commitment proceedings and can you describe that experience?

A. Yes, rather extensively.

In New York State for several years now, we have had a mental health information service, which was set up by state law and which is an arm of the Court that is responsible for commitment proceedings and under this program, every hospital has a lawyer or there are lawyers responsible for several hospitals if the service is small, who is available to all patients—all patients, that includes children, adolescents and adults, to discuss with them their rights and to help them with any complaints they have about being in the hospital.

Q. Have you had contact as a psychiatrist with one of these lawyers for your patients?

A. Yes, extensively.

(22) Q. Do you have any opinions regarding the benefit or disadvantage to those juvenile patients of such contact with attorneys?

A. I think it is proven over the years to be an advantage. The advantages are several-fold.

First of all, it relieves the psychiatrist from wearing two hats, from both having to be responsible with seeing that a patient is apprised of his rights and explaining something that he is not an expert in while at the same time being a psychiatrist.

I think it leaves him free to make a reasonable judgment and recommendation to a patient about hospitalization and treatment without at the same time having to say, "However, if you don't agree, you can go to Court and have this reviewed."

I think at the same time it provides for better legal advice for the patient, because there is an expert who is well versed in these rights advising the patient.



Q. Do you feel that your treatment of juveniles is hindered at all by the juveniles being represented by an attorney?

A. Not at all. I find it helpful.

Q. In cases where there is a disagreement about the need for treatment, do you find that the adversarial (23) stance of the lawyer ever interferes with the best interests of the juvenile?

A. I haven't found it so. I think what happens is that it does not come to a hearing. I think the mere fact that that possibility exists leads to both from the legal point of view and from the psychiatric point of view, the best compromise solution being found to help the patient.

Q. Dr. Kandler, I wonder if you would give us your opinion regarding the reliability of parents of possibly disturbed youngsters as the source of information with regard to commitments?

In other words, do you think that parents should be relied upon to make applications for the commitment of children?

A. Well, I think some parents are reliable and some parents are less reliable.

Some parents are very angry at their children and would like to have the children placed somewhere else and some parents are honestly mistaken in their judgments.

So I think you get a whole panorama of possibilities.

Q. Do you feel that there would be any advantages from a prior judicial hearing for the commitment of a juvenile (24) in a non-emergency situation?

A. I think the advantage is an indirect one.

In a sense that when the possibility of a hearing exists, then those agencies or people that consider that it is in the best interests to have the child placed in a hospital,

have to make sure that the child or adolescent is thoroughly worked up and the case is thoroughly understood and there is an agreement it is in the best interest of the child.

The advantages, it makes a better situation beforehand, putting everybody on notice to do a better job.

Q. Are there any therapeutic aspects to the child in having a hearing or representation by Counsel or an advocate?

A. I think there are two.

First of all, I think what happens is that rather than arbitrarily railroading a child into the hospital, the situation has to be explained to the child very thoroughly and this also goes on once the child is in the hospital that the staff makes an effort to try to explain to the child why he is there and why it is necessary for him to be in the hospital and what type of treatment his is getting and I think that makes a better treatment.

(25) In psychiatry it is difficult to treat a patient without the cooperation of the patient and even at times during an emergency situation one has to admit a patient quickly against his will. Nevertheless, eventually, you need the cooperation of the patient. Even if it is only as simple as taking medication, if the patient leaves the hospital and discontinues taking the medicine it is harmful. Especially in the case of psychotherapy.

The second advantage is it gives the child a sense of trust and responsibility, because he has some other alternative. He can go for advice to someone who is an expert, who may either advise that the child cooperate in the treatment or suggest that the child have a hearing and try to get out of the hospital.



Q. I understand that in New York, as the law is in the City of New York, the hearings are on a challenge to a commitment once it's been accomplished.

Do you see any reason why your comments would not apply to the treatment situation as well?

A. In general, no. There are emergency situations in psychiatry and there must be some procedure by which one can safeguard the patient from harming himself or other people when the situation is one of immediacy.

Otherwise, I think it would apply.

(26) Q. You are generally familiar with the emergency provisions of the Pennsylvania Mental Health Law.

Do you think—

JUDGE GIBBONS: Wait a moment.

Ask him, is he, first.

Q. Dr. Kandler, are you familiar generally with the fact that Pennsylvania has emergency provisions for commitment procedures?

A. I know they do.

Q. Do you feel those procedures are generally adequate for the emergency where—

A. I don't know the details enough of the Pennsylvania law.

Q. Thank you.

Dr. Kandler, would you please explain whether or not you feel there are differences between institutional, inpatient juveniles in a psychiatric facility as opposed to outpatient care or general medical care, differences which merit a prior hearing?

A. Well, I certainly do.

I think when you lock someone up, you deprive him in large measure of control of his life and I think this ought to be done carefully.

Q. Dr. Kandler, do you know whether there are any national medical or psychiatric standards regarding the (27) provisions of legal counsel for due process to children?

A. Probably the most pertinent one is in the latest accreditation manual for psychiatric facilities serving children and adolescents.

Q. Who published that or wrote that?

A. This is published by The Joint Commission on Accreditation of Hospitals.

Q. Who are they?

A. This is an organization that was formed over 20 years by the American College of Surgeons and Physicians and The American Hospital Association and The Medical Association and Their Approval of Hospital Facilities. In this instance Psychiatric facilities for children very often determines whether they get funds and is certainly involved in their getting federal funds and let me quote, they have several sections—

JUDGE GIBBONS: Mr. Ferleger, before the doctor refers to this document, will you have it marked for identification?

MR. FERLEGER: Certainly, your Honor.

(Above referred to manual entitled, "Psychiatric Facilities Serving Children and Adolescents," was marked plaintiffs' Exhibit 7 for identification as of this date.)

JUDGE HUYETT: What is the exact description?



(28) MR. FERLEGER: That is the "Accreditation Manual Serving Children and Adolescents," copyright number 1974, and paid for by a grant from the National Institute of Mental Health.

I think that a reference to the law regarding Medicare and Medicaid provisions will show that these standards are adopted by the Congress as the standards of Medicare and Medicaid aid to Hospitals.

JUDGE GIBBONS: Have you seen it, Mr. Roth?

MR. ROTH: I have only seen it briefly.

Of course, it is not being introduced into evidence. So we reserve objection to that, your Honor.

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*Continued Direct Examination by Mr. Ferleger:*

Q. Are these standards generally accepted by child psychiatrists and proper standards for care of children in facilities?

A. Yes, and throughout this they make a distinction between the standards that shall be made and those standards that ought to be met. So, it is both a standard, plus a guide for the kind of improvement that should be implemented.

Q. What do they say with regard to due process and legal advice for children?

A. "The psychiatric facility serving children (29) and adolescents shall know the dignity and protect the rights of all its patients and their families. Every effort shall be made to safeguard the legal and civil rights of patients and to make certain that they are kept informed

of their rights, including the right to legal counsel and all other requirements of due process when necessary."

Let me add the reason I became involved with this, because I am setting up a day hospital at this moment and as a part of the budgeting for that facility, there is the budgeting for an attorney involved to provide the help to children in this facility?

MR. FERLEGER: No further question.

JUDGE GIBBONS: Are you going to offer that document?

MR. FERLEGER: No, I am not, your Honor.

JUDGE GIBBONS: All right.

Mr. Roth?

MR. ROTH: Your Honor, would you indulge us for just a moment, please?

JUDGE GIBBONS: Yes.

MR. ROTH: Thank you.

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*Cross-Examination*

BY MR. ROTH:

Q. Dr. Kandler, would you please indicate what experience (30) you have and the duration of that experience in admitting adolescents?

A. I have been affiliated with the in-patient services of Bronx Municipal Hospital Center for 16 years and while being on that staff I was for five years supervising psychiatrist at Bronx State Hospital.



Both of these facilities are run by the Albert Einstein College of Medicine, so it is possible to have responsibilities in both areas.

Q. Would those facilities be considered an institution?

A. I'm not sure of the medical definition of institution. Certainly the State Hospital would be considered an institution. The other is a city hospital with a large psychiatric facility.

Q. The ones you work with are the city hospitals?

A. And for five years a state hospital.

JUDGE GIBBONS: Both in-patient facilities?

THE WITNESS: Yes.

Q. What was your role at the institution when you worked there for five years, were you the admitting psychiatrist of adolescents and juveniles?

A. I was first of all assistant director of a 3-ward unit which we used for training purposes for our residents. As such, there were five residents on my ward. I was responsible for the ward and I supervised them with all (31) their cases on the ward.

Now, in that particular instance, we didn't do particularly the admission, but when they were referred to us, we screened them. In other words, they would have often been at the city hospital and we would select them as being appropriate for this facility for their treatment. So, it was a selection process, rather than an admitting procedure. They were rarely admitted directly to the service, although at times they were.

Q. Do you believe in institutionalization?

A. I don't understand the question. In what regard?

Q. Well, in the sense, Doctor, that you testified with regard to out-patient treatment as well as in-patient.

Do you believe placing one into an in-patient residential facility, and in the State of Pennsylvania, a state mental hospital?

A. I think there were instances where patients have benefited from hospitalization.

Q. Now, Doctor, with regard to some statements you made, you indicated that a lawyer should see a juvenile; is that correct?

A. I think it is very helpful, yes.

Q. When do you think the lawyer ought to see the juvenile?

A. Well, I think there are two instances.

(32) One is before someone is hospitalized and one is after.

I think before one has to be very careful to be able to admit a patient quickly when a patient is in danger of hurting himself or someone else. There has to be some emergency way of taking care of someone who is in acute psychological difficulties. It is something that has to be planned and if there is an objection by the child, I see no reason why this could not be done before hospitalization.

Now, what happens is that one of the problems with psychiatry is that its prognosis is difficult and certainly predicting future behavior is most difficult, so I think it is very important after someone is admitted that legal help be available to someone after they are in the hospital.

Sometimes somebody is upset for a couple of days and then they improve and in a time like that if they are not easily discharged, they ought to have some recourse available.



Q. With regard to the manual which you read parts of on accreditation standards and recommendations, did that manual indicate if a hearing should be held for a juvenile prior to admitting into an in-patient residential facility?

A. Not that I recall.

Q. Doctor, would you please explain the admission (33) procedures there, with regard to juveniles?

Let me be a little more specific.

May a juvenile be admitted by a parent in New York?

A. Only a doctor can admit a patient to the hospital.

Q. May the parent make application for admission of the juvenile to the hospital after the doctor has recommended hospitalization?

A. Yes, they may.

Q. Is there a hearing afforded to a juvenile prior to his hospitalization?

A. Well, that's an interesting question.

It is not excluded, but I have never come across it in the order of events of admission.

Q. Well, Doctor, let me ask you this:

You have testified with regard to the admission procedures in New York in some terms and I am just asking you, do you know from your experience, if it is in fact in law that a juvenile is given a hearing prior to admission?

A. He is not given one, but I think—I personally think, it would be possible for a child to ask for one under the way that I read the law, but this is not my area of competence.

Q. Doctor, do you feel qualified upon evaluating a (34) young person to recommend a treatment for him or her or to recommend in-patient residential care?

A. After my evaluation, yes.

I may want other people to help me in that evaluation.

Q. Do you feel you need a corroborating opinion before placing a youth into any program?

A. Not necessarily. No.

Q. When a juvenile comes to you and I would assume—

MR. ROTH: Strike that, please.

Q. Let me ask you this.

Does a juvenile who needs help, let us say, come to you generally through his parents?

A. That would probably be—with his parent, not necessarily through his parent.

Q. With his parent?

A. Yes.

Q. When the parent and juvenile—

A. I mean, I want to elaborate that.

Very often it may be the child's wish to see someone and the parent acquiesces. Our problem is treating children who want treatment without the parents' knowing, not the other way around.

Q. When the parent is before you and the juvenile is before you, do you formally evaluate the juvenile?

(35) A. As well as the parent.

Q. Do you feel in some circumstances, it is important to review the parents?

A. Nearly always.

Q. Now, Doctor, how important is the family structure in terms of the development and growth of children?

A. What do you mean by "family structure"?



Q. For example, you have testified that some parents are reliable and they bring their child to an institution and you observe their behavior pattern and you testified that some are not as reliable and some are unreliable, and I am questioning how important is the family structure in terms of allowing the parent to seek this type of help for their juvenile—for their child?

A. I am still not sure of what you mean by "family structure".

Q. Doctor, I will take it from another avenue and I think it will clarify it more.

Do you think that parents generally operate in the best interests of their children?

A. Generally.

Q. Do you think that parents have a callous disregard for their children and are merely attempting to plop their children into institutions?

MR. FERLEGER: Objection as to the phrasing (36) of the question.

JUDGE GIBBONS: Overruled.

Q. Please answer the question.

A. It happens. I think the majority of parents have the best interests of their children at heart.

I think mostly where I am concerned about the issues that we are talking about here is—

Q. Doctor, I am sorry to interrupt you. I'd like—

JUDGE GIBBONS: That is a responsive answer.

A. I think some parents callously would like to get rid of their children, though the biggest number of chil-

dren who may not get the best possible treatment occurs where there is ignorance on the part of the parent.

Q. I'm sorry, I didn't get that.

A. "Where there is ignorance on the part of the parent."

Q. Do you feel there would be a conspiracy between parents and physicians and psychiatrists to place children into institutions?

A. No, I don't think so.

Q. Doctor, do you feel that most parents don't want to be separated from their children?

A. Most parents do not.

Q. Do you think that parents who have economic means and are able to doctor-shop in order to obtain treatment for their child without recommendations for institutionali (37) zation are better equipped as parents than those who come from poor socio-economic backgrounds and cannot doctor-shop?

MR. FERLEGER: I object to the question.

I don't understand the question, myself.

JUDGE GIBBONS: Do you understand it, Doctor?

THE WITNESS: I think I understand what he is driving at.

JUDGE GIBBONS: Objection overruled.

A. I don't think the variable is money. I think the variable is knowledge.

There may be some slight correlation between education and money. However, I think very few of us, when we are in trouble seek a second opinion. I think this is



a problem that is generally true. I think the population at large isn't discriminating enough in selecting all of their physicians.

Q. We are talking about the education and awareness of parents of meeting their children's needs, I would assume, and would you not feel that parents who perhaps may have a bit more education and are able to afford, if you will, more expensive treatment, generally doctor-shop, not necessarily to find one who will recommend institutionalization, but in order to find an evaluation (38) where they will not have to be separated from their child?

A. I think people doctor-shop to find a physician that agrees with them and that may be right or it may be wrong.

Q. Doctor, under—

A. As a matter of fact, there is a study that people overweight tend to go to doctors overweight.

And I think the same thing is true in psychiatry, that there are so many modalities of treatment that people try to find somebody who agrees with their opinion.

Q. Isn't that precipitated by the fact that parents do not want to be separated from their children?

A. That is not the issue at this juncture.

I don't think that that issue comes up. I think if they think about it at all, they are more likely to think they can't handle the situation, rather than worrying that the child would be forcibly taken away from them.

Q. Are you familiar with the procedure of parents making application for their children in Pennsylvania?

A. Somewhat.

Q. Would you please explain what you think the situation is for voluntary admission of children by parents?

A. The parent can petition to have the child institutionalized.

(39) Q. Do you know what the safeguards provided are for the screening of the child prior to institutionalization?

A. Prior to this case, there were none, but since this case, regulations have been set up that children from 13 to 18 can have legal advice, but there are no provisions for children under 13.

Q. Doctor, I do not think you have been totally informed about the safeguards.

With regard to juveniles, in order to get your opinion on whether or not this procedure is acceptable to you as a professional—

A. Juveniles at what age?

Q. It refers to youths from age zero to age 18. We are not restricting ourselves to juveniles or adolescents, but any juvenile 18 and younger, whether he is mentally retarded or mentally disabled may not be admitted to an institution until he is referred from a recognized medical facility, mental health, mental retardation therapist or mental health agency—

MR. FERLEGER: Mr. Roth is reading from the regulations and I must object.

JUDGE GIBBONS: He is laying the groundwork for a question and don't object until he asks the question.

MR. FERLEGER: His necessity to read it may also necessitate that Dr. Kandler have it in front of (40) you in answering the question.

JUDGE GIBBONS: Bring it up and let the witness look at it.



MR. ROTH: May we have a moment, please?

JUDGE GIBBONS: Are you referring to annex "a" to title 55?

MR. ROTH: Yes, I seem to have it attached to something—

JUDGE GIBBONS: I have handed him our copy.

Q. Can we look at page 1 and under numbers 1 and 2, it indicates how juveniles are, if you will, reviewed prior to their ultimate admission into an institution and in a form of summary, what basically occurs is that there is a referral unit and that referral unit be an individual therapist or a base service unit in Pennsylvania who will evaluate the child and we assume total evaluation of family, et cetera, in order to come to a disposition of whether or not the juvenile or child should be afforded admission into an institution.

Subsequently, the parent takes that child to the institution which is recommended by the referral unit and the director at that institution causes an individual examination to occur.

Now, at that point, if the individual examination corroborates the first, then admission is (41) made of the juvenile by the parent.

Now, do you think, since you have already testified that you feel confident to make a recommendation to either institutionalize or recommend mental treatment for a juvenile, do you think their screening devices are appropriate?

MR. FERLEGER: Objection, your Honor.

The question is not making recommendations. Dr. Kandler had not been asked whether admission should occur on a recommendation of his or anybody else's.

We don't question the right of referral agencies to make recommendations. All we question is who the decision maker should be.

JUDGE GIBBONS: Overruled.

You may answer the question.

A. The procedure sounds very good on paper, but unfortunately, there is a large gap between outlined procedures and the quality of the kind of evaluation the patient gets and my concern is with that quality.

I don't know the details of what the examination consists of. It isn't spelled out at all in this regulation. It can be a five minute chat with someone. I think it is good as far as it goes, but the only way for me to judge whether the procedure is good, I would have to know the people who are making the (42) examination, what kind of tests are done and so forth.

Q. Well, Doctor, assuming—now, assuming that the evaluation is done according to, if you will, generally accepted principals in psychiatry, would that satisfy you?

A. It would satisfy me.

I would have one worry about it and that is even carefully done psychological evaluations, the prediction of behavior is rather limited. People change and an evaluation takes a couple of months and it takes another month to get someone into an institution and there might be a vast change in an adult or child for that matter and I don't think it is enough for this evaluation to have taken place before hospitalization.



I think after hospitalization, equal care has to be taken and there must also be alternative judgments available after one is hospitalized, especially one which deprives one of his freedom.

Q. This case does not involve the right to treatment. The plaintiffs have not made any allegation that treatment is not being afforded to juveniles—

A. I was talking about keeping somebody institutionalized. I think that should be reviewed periodically.

Q. Doctor, without going far afield, that is a necessary part of treatment.

(43) Do you not evaluate as part of your treatment process, a person prior to his admission to a facility as well as subsequently?

A. I do.

Q. Don't you consider that part of the treatment process?

A. Absolutely.

Q. Now, assuming again, Doctor, that although on paper, we do not have outlined what one must do, a psychiatrist or a base service unit or anything of that sort in order to evaluate a juvenile, but recognizing them for acceptable facilities, do you feel that that two-step process is acceptable to you in terms of the recommendation that may be made to the parents as to whether or not the child does need institutionalization?

A. It is difficult for me to answer that directly the way you put the question.

I know from experience that even though there are regulations that the criteria for admission to an institution varies widely from city to city. I know that is true in New York City.

It is better when you have more than one judgment. No institution ought to be forced to treat someone who they don't think belongs in the institution and therefore, the director or his delegate should judge (44) whether somebody ought to be in his facility.

It is hard for me to say this is adequate because so much depends on how this is done and I know from experience that the statistics for admission to equal facilities within the same area vary widely.

Q. If you felt that parents and physicians and psychiatrists are acting in sort of a conspiracy to place children into institutions and as I recall—

A. I found no conspiracy between the three of them.

I think at times families cannot handle their children and try everything possible to get people into a hospital without necessarily relying on expert advice and I think most of the difficulty comes because unfortunately, there are nowhere near adequate facilities to take care of those people who need to have care.

There is not enough staff to do the job the way it ought to be properly done and things are slipshod.

Q. Do you feel for example, yourself, as a professional, if I were to come to your place and if I had a child and brought that child to you and you evaluated the child and the child did not need institutionalization and I said, "I really want this child in your institution," would you put the child in the institution?

A. No, the parent would take the child to someone else, (45) presumably someone more prone to institutionalizing of children.

Q. Along with those procedures, we do have a procedure and again reading down the page and particularly,



I alert you to number 6, we do have a procedure where every juvenile, age 13 or older, is given notice of the reasons for his admission and he is provided with a telephone number of the person who made application for him, which, by the way, Doctor, is limited to a parent, guardian, a person standing in locus parentis and he will be afforded counsel if he objects subsequently to admission and you have testified according to your law, there is no law indicating a juvenile must be given a hearing prior to admission and that the J.C.H. standards do not indicate this should be done.

Do you think a juvenile should be afforded this type of procedure?

A. Here it states, "13 or older." It eliminates younger children and I would disagree with that, and, secondly, excepting emergency children, it is a dangerous thing to remove a child from his environment and family and so forth and I think if there is serious conflict between the parents involved, including objection from the child, I think the child ought to have some representation, whether it be a psychiatrist or lawyer of his (46) choosing and I think this will help the children at a future time, if the child is convinced that what is being done for him is in his interests rather than anyone else's. I think it will help treatment in the future immeasurably.

JUDGE GIBBONS: Doctor, you indicated that you disagreed with the cut of age of 13 for notice purposes.

Do you have an opinion as to at what age a notice provision would be meaningful?

THE WITNESS: Well, I thought about that question.

It is difficult for me to answer that. Thirteen is not a bad breaking point, because we arbitrarily divide adolescents and children. I think younger children need protection and I have been in contact with the deputy director of our Mental Institute Division and they are concerned about that because they are less able to make decisions and ask for help and they consider it a specific duty of theirs to look in on the situation in our children's ward.

As to the actual notification of a piece of paper, that would be an adequate breaking point, but some representation for these children should be made.

They are less able to object, to be able to get a second opinion.

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(47) *Cross-Examination Continued*

BY MR. ROTH:

Q. Doctor, with regard to the advantages of having a hearing prior to the admission of a juvenile, as I understood your response to that type of question from opposing Counsel, you felt that it is better to treat a child who is cooperative, rather than one who is uncooperative; is that correct?

A. Absolutely.

Q. Do you feel that by providing a hearing, where a judge might order a child to be institutionalized, that that is going to affect the child's attitude in cooperating with treatment?

A. It would be better if that were not necessary, but at times, rarely, but at times, a child has to, or an



adult for that matter, has to be institutionalized in order to begin the treatment.

The purpose of treatment is to make the child cooperate with the treatment.

In New York State, we specifically request—we are requested by the Mental Health Law that we reduce the degree of institutionalization. It is not good to have someone, except for an emergency situation, to be admitted against their will.

Q. Doctor, in your experience, do you feel that generally adolescents will not tell you when they are depressed (48) because they wish to avoid the entire affair?

A. Adolescents take a different form than adults.

I am not so sure that few of them complain. They won't call it depression. I think adolescents complain and complain a lot. Perhaps they complain more than adults. The form of their complaint will take other forms. Complaints about authority and school and parents and so forth. They will less rarely come in and say they are depressed, because depression as we know it in adults is something which really occurs more frequently with adults.

Q. Is it not true that juveniles have a reputation as being unmotivated for treatment?

A. I do not find it so.

Q. You do not find that juveniles resent authority and constantly are rebelling to types of authority?

A. To authority, yes. I think that is a part of growing up.

Q. Do you not feel that being admitted into any facility is a type of authority?

A. Well, that depends whether you do it voluntarily or not. The true sense of the word, not the way the law in Pennsylvania defines it.

Q. Do you know of any juveniles that really like the idea of going into an in-patient residential facility?

(49) A. Absolutely. In our wards we have more trouble discharging patients than bringing them into the hospital. They want to stay.

Q. Do you find that juveniles who are objecting are really not objecting in the sense of you and I saying, "No, I don't want to do something," but it is really a so-called plea for help in which they want somebody to help them?

A. That is sometimes true.

Q. Now, one thing I don't want this Court to be misled with, Dr. Kandler, and that is the fact that every child is recommended for institutionalization.

Now, don't you feel, for example, in your practice, what percentage of juveniles or children, rather, come to you do you not recommend for in-patient residential treatment?

A. In my private practice, it is very, very rare.

Our statistics at Jacoby Hospital—first of all, adolescents, some 30 to 40 percent of our adolescents that come to our service come from a Family Court. Out of the remainder, we admit between 20 and 30 percent.

So that means that 60 percent, 70 percent would be referred elsewhere—those that appear in our emergency room, 70-80 percent, rather would be referred (50) to your clinic or some other social agency. Twenty to thirty percent of those coming to our emergency room are admitted. Other facilities, however, this may be double that number.

Q. Doctor, with regard to the section we are discussing, we are talking about non-emergency commitment.



Now, you have already testified that you have some knowledge of the emergency commitment provisions in Pennsylvania.

A. Yes.

Q. Do you feel that every juvenile is a potential emergency situation?

A. Absolutely not. Every juvenile where?

Q. That is being admitted to a facility.

A. There are different facilities, different situations, different hospitals. I can't answer that.

Q. For example, I believe Mr. Ferleger indicated to you that a hearing is provided for an emergency commitment?

MR. FERLEGER: I did not.

MR. ROTH: Strike that.

I'm sorry.

Q. With regard to the 405 Commitment Section, it deals with an emergency provision and states, "One is dangerous to himself and others and can be detained without a (51) hearing—"

A. Yes.

Q. —I am asking you, with regard to juveniles, although their situation may not appear to fit those needs—to fit those limits, if you will, "being dangerous to self or other," do you feel, Doctor, that a juvenile may be a potential emergency situation if help is not given right away?

A. Are you asking whether a situation would get worse if someone is not admitted, even though if it is not an emergency?

Q. If he is not immediately treated.

A. That is possible, but he can also get better.

I have known instances where hospitalization has been put off and the need for hospitalization has disappeared.

Q. Don't you feel it could be traumatic for a juvenile to be in a hearing and all sorts of facts coming out about his need for institutionalization are before him?

Don't you think that could be traumatic for a juvenile?

A. It can be, but my experience has been that it is helpful for the patient to know what other people think of him, including diagnosis.

Q. Doctor, with regard to the entire procedure, where, (52) from my understanding, your recommendation is that a hearing occur prior to institutionalization, do you not feel—

A. I recommend it ought to be available. I think it ought to be avoided if possible, but it ought to be available.

Q. In other words, if there is a conflict between the juvenile and the parent, do you feel that a hearing should be given?

A. I think a hearing should be available to the person who objects to being hospitalized.

Q. Do you find any problem with giving that hearing after the person is hospitalized?

You know, precipitating—

A. I think hospitalization is a very serious affair and unless it is an emergency situation, this possibility ought to exist before.

I am interested in forcing the system to have proper care beforehand so a hearing won't be necessary, so all parents can come to the conclusion what is the best treatment for the patient.



Q. Let's assume that we use the safeguards we have in Pennsylvania, where somebody is screened at step one, the parents are evaluated and the child is evaluated and there are recommendations made to the parent and child, (53) unfortunately, the recommendation, if you will, cannot be anything other than institutionalization and then we go to step 2 and the child and parents are again evaluated by the psychiatrist and the recommendation is made that the juvenile should be admitted into the facility and the child is screaming bloody murder, he does not want to go, and do you feel at that time that the child should be permitted to be institutionalized by the parent and if the child continues to object, then he can be afforded a hearing and in accordance with what you said, all the processes, do you feel the legal processes have been satisfied?

A. By the definition, emergencies ought to be admitted and non-emergencies can wait.

There is no reason to make a decision about a child that may affect him immediately for months and years and perhaps for his lifetime. That decision does not have to be rushed into. I don't see why if you take two safeguards, you can't take a third.

Q. In other words, on one hand, you are saying that a hearing should be given and—

A. I think a hearing ought to be available if the parties concerned can't agree upon what the best treatment for this child is and that would include the child.

Q. When you say, "Parties can't agree," whom do you (54) mean by "parties"?

A. Primarily the child, of course.

Q. So, you feel that a child that is, let's say five years old, is well enough aware of his situation that he can even make a recommendation or a statement as to

what kind of treatment or where he should be placed; is that what you are saying?

A. I think a five year old child that complains of pain, I think it ought to be considered seriously. I don't think he is necessarily right, but he has a right to have someone look into that situation, whether it is a physical pain or mental pain.

Q. Don't you think that pain is being looked into by the psychiatrist?

A. Yes, but we all make mistakes.

Q. Are you telling me that psychiatrists make a large number of mistakes with regard to recommending any treatment programs for a child?

A. I don't think it is large, but I think it is considerable and if it is you, I think it is very important.

Q. Do you make a lot of mistakes?

A. I hope not. I have made some.

Q. Now, Doctor, how essential do you think the role of the family is in terms of having a parent admit his child? Do you think that it is important for the parent (55) to be able to admit his child after he has received recommendations from phase 1 or phase 2, that is, the two steps, if you will, that is recommendations by professionals that the patient be institutionalized, do you think it is proper for the parent to be able to admit the child at that point?

A. Yes.

Q. Doctor, do you feel—

A. I mean, it is important, but as I said before, if it is not an emergency procedure, it is not so important that one need to ignore a child's objection.

Q. Aren't there ways of dealing with a child's objection, other than having a hearing prior to admission?



A. I hope so. The best situation is to get a child to cooperate with the treatment and believe in the treatment.

Q. Let's assume this: Say a parent—you just testified that the parent should be able to admit the child at that point.

What if the child objects to that?

A. You didn't ask me that.

Q. I am asking you that now.

What if the child objects to the parent admitting him?

A. I think the child ought to have someone that he feels is on his side, some professional, whether it be (56) a psychiatrist or attorney, if it is a legal question.

Q. I asked you before if you felt parents operated in callous disregard of the best interests of their children and you said that parents are [not] really operating in disregard for their children's interests.

A. I don't think I can make a general statement like that. I think it happens at times. I think the instances that mostly come to my attention where there are good intentions, but bad results.

Q. So then, Doctor, would it not be fair to assume that if there are abuses of this sort occurring, that perhaps, the way to deal with those abuses is to make sure that the evaluating psychiatrists are not, if you will, making errors in terms of evaluating the parents and the juvenile?

A. There is no question that we should have more psychiatrists and the best possible trained psychiatrists and unfortunately that is not true now.

Even the best psychiatrists make mistakes and there have to be secondary opinions available in medicine as there are appeal provisions available in the law.

Q. Doctor, what we have here is we have already two psychiatric opinions, if you will, in step 1 and step 2 and let's say the child—would you recommend another (57) psychiatric opinion?

How many psychiatric opinions would you recommend prior to admitting a child into an institution?

MR. FERLEGER: I object.

He already testified that he thinks a legal hearing is the best thing and I think this is getting redundant.

A. Well, I will add something to that.

JUDGE GIBBONS: One moment. Objection overruled.

A. It is very difficult to talk numerically.

What I am most concerned with is that the child have someone that he feels is there for his interest and not for his parents' interest or some school interest or social agency's interest or anyone else's interest.

How this is done procedurally can be done in many different ways, but I think it is important; quite apart from reaching a valid psychiatric judgment, you have to have the trust of the child. That includes a measure of confidentiality. A child can't possibly believe in you and confide in you, if the result is going to be that the psychiatrist isn't going to work with the child, but is going to work with the parents' recommendation that the child has no part in.

Q. Don't you feel that children are comforted and feel (58) loved and cared for by their parents?

A. We are talking about instances where the family structure has been disrupted. We are talking about instances—



Q. I am not talking about—

A. You are not talking about the normal family.

JUDGE GIBBONS: Can you give us some indication how much longer your cross-examination is going to be?

MR. ROTH: I think perhaps 15 minutes.

JUDGE GIBBONS: I think the court reporter would appreciate a recess at this time.

(Whereupon, a recess was taken.)

(All Counsel and parties being present, the following transpired in open court.)

JUDGE GIBBONS: Back on the record.

(Witness resumed.)

MR. ROTH: Your Honor, may I have the last question read, please, by the court reporter?

JUDGE GIBBONS: Mr. Reporter, would you read him the last question?

(Whereupon, the above requested portion of the record was read by the court reporter after which the following transpired in open court:)

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(59) *Continued Cross-Examination*

BY MR. ROTH:

Q. Doctor, do you feel that if you have an adversary process between—or if you have a proceeding whereby the juvenile can be given a hearing prior to the admission by the parent, don't you feel that the adversary relationship that is created between the parent and the child

will ultimately be disruptive to that family's structure in the event the child is ever returned to the family again?

A. I can't see how the fact of the hearing will make it any worse than it is, since obviously the disagreement exists before the hearing.

Q. What if a parent wants to put a child into a general hospital and the child is objecting there and the parent prior to putting his child into a general hospital has had the child evaluated by two or three neurologists and the child objects at that point; do you feel there should be a hearing?

A. I have very little experience with that kind of a situation, but it is my belief that that ought to be available. I don't think it would happen very frequently, but as I have said before, we all make errors and I think in an extreme situation that ought to be so.

Certainly I have known many instances where children have been forced to submit to something that was (60) unnecessary.

Q. Doctor, is it not one of the, let us say, legal requirements for parents to seek medical care for their children when they need it?

A. Yes.

Q. Do you not feel that parents who can't seek medical care unless they have to take part in a judicial proceeding, that they will not seek medical care?

MR. FERLEGER: Objection.

Unless you can define what he means by medical care. He has not testified to medical care—

JUDGE GIBBONS: He just did. He testified to a question about a neurological problem.



MR. FERLEGER: I want to make it clear that this case in the complaint or anywhere in the record that nowhere do we allege that neurologists need a prior hearing.

JUDGE GIBBONS: The question is the availability by a hearing device, would that tend to discourage parents from seeking medical or psychiatric assistance?

A. As a psychiatrist, it is my judgment and my experience that if a family can't work out situations such as a child going into a hospital, then there is some difficulty in that family. It may not necessarily be of any major proportion, but I would think it would occur very (61) rarely that a young child would go to court, but I think that possibility ought to exist.

I think that people do get unnecessary surgery; I think parents get involved with fads, with all kinds of quack treatments and there should be something available in an extreme situation that a child should have someone else to turn to.

JUDGE GIBBONS: You haven't answered the question.

Would the availability of this hearing device tend to discourage parents, if you will, parents in families where there are problems, from seeking assistance for their children?

A. I don't see why it would, because I think the issue of a hearing does not come at the point where you seek advice and help. It usually comes after you have gotten the advice and help. I don't see how it could.

Q. Then, Doctor, is it my understanding that anytime a parent wishes to obtain medical care, by the psy-

chiatric or non-psychiatric care for his child and there is an objection by the child, then, you would handle that by doing what plaintiffs' recommendation is, by having a hearing prior to admitting that juvenile or child into a hospital; is that correct?

You would have a hearing in every (62) circumstance?

A. At that juncture, I would try to persuade the child as to what is involved and what is necessary and why it is necessary. If it is not sufficient or if I am identified in the child's mind with the parents, I would see the child has a chance to talk with an expert who has not been involved in the proceedings up to that point and after that, I would think a hearing or legal representation in some way certainly would be helpful and would be helpful to the child psychologically in terms of his accepting the procedure to be performed and it certainly would make his cooperation more likely, which might be very necessary in some forms of treatment.

Q. Would you say that hearing would make the child more acceptable toward the ultimate treatment?

A. It may.

Q. Do you have any statistics to reveal that it would?

A. I do not. I have some experiences, but no statistics that would be meaningful in a large context.

Q. Do you feel there to be any stigma attached to having a juvenile undergo a hearing prior to admission, where he is now court ordered to a mental health facility?

A. No, I don't.

Q. Why not?

A. Unfortunately, there is a stigma being attached to (63) being in a hospital, which would be another reason



why all care ought to be taken before this type of drastic step be taken. I never heard the fact that a judge or attorney being involved in a proceeding increases that stigma.

Q. Doctor, do you realize what the nature of this lawsuit is doing, that it is going to have juveniles or children, we have not distinguished ages, that they will be treated the same as adults?

Do you feel that children are—you say zero to 18 should be treated the same as adults?

A. Yes, I do, in this regard that you are talking about. I certainly do.

Q. Do you feel that there are not developmental differences between a 19-year old and a 1-year old?

A. I certainly do.

Q. Do you feel that one who is an adult is generally more aware due to his experience and development to seek treatment if he needs it, than perhaps one who is age three or four?

A. Well, one has to be very careful about what age you are talking about.

Certainly in general, one's judgment increases over the years. By and large adolescents may have the kind of judgment that is required of adults, (64) although I think the issue of the way we develop judgment, it continues for many, many years. Someone who is four or five may have better judgment than one at twenty-one. It is arbitrary as to which you make the breaking point in terms of age.

If someone objects or thinks he has an objection, it is important to take that seriously. It is not necessarily true whether one is right or wrong.

Q. Have you discovered the percentage of cases in New York where juveniles are admitted incorrectly? Do you have any idea as to that?

JUDGE GIBBONS: Admitted now to a psychiatric residence facility?

MR. ROTH: In-patient.

A. I have no idea incorrectly, because presumably, if they were admitted incorrectly—there are two aspects of this, whether psychiatrically incorrect or whether when a hearing is requested, the Court rules that they ought to be discharged.

That happens quite frequently with adults. Our experience with adolescents has been this way:

The mental health review service has operated for several years and to the best of my knowledge, there has not been a hearing. That is important as to what you are asking, whether five-year olds will clog (65) up the courts and so forth.

I cannot recall an actual hearing taking place with an adolescent, someone that was not referred to us from the courts, I am talking about, because the attorney in discussing the rights and the issues with his client usually helps him to negotiate in some way with the psychiatrist to find some way for the treatment to continue.

Now, at times treatment does not continue with discharged cases where our advice has been that a child should remain in the hospital, but we didn't feel it was an emergency situation. We felt at this point it was better for the child to leave the hospital.



Very frequently they come back and they request clinic care and that treatment is usually much better than if one continues to keep a child in a hospital forcibly.

Q. Are you saying all your admissions are pursuant to court order that you have dealt with?

JUDGE GIBBONS: He did not say that.

A. No. What I was referring to was some 30 percent of our cases come from Family Courts where the Court has been involved rather than from social agencies or walking in by themselves.

Q. And the remainder of those does not involve any (66) court proceedings?

A. That's right.

JUDGE BRODERICK: Of that remainder, would you have any idea of what percentage of the admissions were based on an emergency situation?

THE WITNESS: Well, it is the majority. I would guess that 80 percent, maybe more.

JUDGE BRODERICK: Eighty percent are emergency situations?

THE WITNESS: Yes.

JUDGE BRODERICK: If the 80 percent are emergency situations, what part of the 20 percent would be as a result admitted pursuant to a court order?

THE WITNESS: I don't know of any instances where there was a court involved beforehand purely on the basis of the advice of the physician.

We do have that 80 percent that comes to the Family Court that comes from a court order, but that

other 20 percent, they are voluntarily admitted, where the doctor and patient works out that they should be in the hospital.

Q. Of that 80 percent that require emergency treatment, what do you mean by "emergency"?

A. That a child is judged to be immediately in danger of himself or to others.

(67) Q. Are there any provisions in New York law that permit somebody to be detained?

A. Yes.

Q. Why weren't they admitted pursuant to that section?

A. It is usually felt that that is a rather—first of all, some of them are.

Q. For those who are not.

A. Those who are not, we are incumbent to try to admit people and put people on the least stringent form of restraint, so that if someone comes to our emergency room or agrees with the doctor or says it is all right for them to be in a hospital, we will admit them on a voluntary basis.

There is even a provision in New York law that is even less formal than voluntary, informal basis where a patient is admitted where there are no legal records that the patient is admitted and I think the more we have of that, the better kind of psychiatric care we will be able to give the patient.

There are patients who need to be in the hospital under restraint. It is much better to get the patient to cooperate and all treatment is geared towards making the patient cooperate.



JUDGE GIBBONS: Is there any procedure in the hospitals that you have been affiliated with where (68) juveniles can voluntarily admit themselves without parental admission?

THE WITNESS: No, they can get out, but they can't get in.

Q. Are you aware of any situations in Pennsylvania where juveniles have been admitted inappropriately into state mental facilities?

MR. FERLEGER: Objection, he is not qualified on the situation in Pennsylvania.

JUDGE GIBBONS: The question now is, is he aware and he may answer that yes or no.

A. I don't know of any cases at all in Pennsylvania.

Q. Doctor, do you often testify in court cases?

A. No, I do not.

Q. Are you being compensated for your testimony today?

A. Yes, I am.

Q. How much are you being compensated?

A. Two hundred dollars—I am charging—that is my bill.

MR. ROTH: Your Honors, I have no further questions.

JUDGE GIBBONS: Any redirect?

MR. FERLEGER: Just one question.

*Redirect Examination*

BY MR. FERLEGER:

(69) Q. Just one question, Dr. Kandler.

With regard to the various percentages that have been discussed, you testified that in your facility, the number of children admitted, pursuant to, I believe you said, the voluntary provisions, admitted as an in-patient may be less than half of those at other facilities.

Could you explain why other facilities may be admitting many more juveniles than you would be?

A. Well, I can't talk specifically about juveniles, but we did a study with adults a few years ago, comparing our facility and I think it will answer your question, also.

I don't have the specific answer for children, but this included all admissions which included some children, but I don't know what the breakdown is and we compared our admissions with the Bellevue Hospital, because of some administrative—the situation—what happened was, that all the patients from Lincoln Hospital were all technically admitted to our hospital and their hospital. They were judged by Lincoln Hospital psychiatrists to need admission in a psychiatric facility and Bellevue and we would make individual decisions whether we agree with them or not.

After this initial screening, we only (70) admitted some 50 or 60 percent of those patients while in Bellevue over 90 percent were admitted.

Q. Why would that difference occur?

A. The difference in philosophy, the amount of help available and the amount that could be placed in the facility.



Q. So, you disagreed with the initial admission in a little more than half of the cases?

A. Yes.

Q. And in Bellevue they disagreed sometimes, and then sometimes they did not disagree?

A. That's right.

We had clinics available; we had day hospitals available; so that obviously sometimes, you hospitalize someone because that's the best alternative for the patient at the time although it is not a good one and at our facility where there were other alternatives possible, some did not have to be hospitalized.

There was no disagreement about the diagnosis or pain or trauma, but we had other means available.

MR. FERLEGER: No further questions.

MR. ROTH: Just one question.

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*Recross-Examination*

BY MR. ROTH:

(71) Q. You said no other alternatives were available. My question is:

If a child is recommended for institutionalization, don't you think that normally occurs after all other treatment modalities are explored by the examining psychiatrist?

A. That is such a general question, I can't answer it.

In some places a psychiatrist will be careful about it and in other places he will not. I don't know how I can answer that numerically in a way that would be meaningful. He should.

MR. ROTH: Thank you.

JUDGE BRODERICK: Doctor, you indicated from your testimony that you were concerned about the possibility that a juvenile may end up in in-patient care that did not belong there. Let me ask you this:

Do you think that it would be sufficient protection if the child who objected were given the opportunity to get an individual psychiatric evaluation?

THE WITNESS: I am not sure I understand how to answer that.

That would be preferable for a step. So often, children find themselves dealing with people who do not represent them and as I said before, with psychiatric issues it is most important that trust and confidence (72) be established not only for treatment purposes, but for relation purposes and what happens beyond that is a legal question which is difficult for me to answer.

You are posing a question if what would then happen if the child disagreed with his own consultant.

JUDGE BRODERICK: Would you think a preadmission hearing would be necessary if the individual psychiatrist had agreed with the other two evaluations or that as the attorney for the Commonwealth indicated was usual in these cases?

THE WITNESS: From a psychiatric point of view, I would be happy and satisfied if a child could have a psychiatrist of his own choosing or some one individual. For the legal requirement I am not sure



I can answer that question as to what would be sufficient.

JUDGE BRODERICK: I am not asking you to answer the legal qualifications. I am asking you whether you see any value to a legal value where the child who objected had the opportunity or an evaluation by a psychiatrist and who agreed with the others there should be in-patient care for that child?

THE WITNESS: I am trying to imagine the ramifications as to what would happen. Obviously, if there is a hearing, the hearing could be wrong, too.

Whether it is a psychiatrist or more (73) formal hearing situation, there could be an error.

I would have to say just as though there can be an appeal from a hearing, there ought to be some appeal at some place.

JUDGE BRODERICK: Even where you have the individual psychiatrist agreeing with the other two, you feel there is an advantage to having a full hearing?

THE WITNESS: There is just too much chance to error and I would agree, it is something that could affect the large segment of a person's life.

Even with a child, even a couple of months is a tremendous area of his life. It has ramifications because children grow so rapidly.

JUDGE BRODERICK: Have you in your experience in New York ever been confronted with a situation where the parents of a child wanted the

child to be admitted for in-patient treatment and you thought that in-patient treatment was not necessary?

THE WITNESS: That happens frequently, of course, where a parent must say, "I really think the child should be in the hospital." What happens usually, we work with the family as well as with the children and most of the time, some agreement is reached where the child should or should not be in or some other form of treatment should be instituted whether the child should (74) be in the day hospital or in the clinic, so that is the goal of treatment to get everyone working together and the precipitating event to that situation is something that has to do with the parents and with the child as well.

Most times parents say, "I want my child hospitalized," and we say, "It's not necessary."

JUDGE BRODERICK: Are you saying most of the time a parent wants in-patient treatment for a child—

THE WITNESS: I was thinking where a child is brought to the emergency room.

There is a big difference where a child is brought to the emergency room or to the clinic and parents do some preliminating sorting. If they bring the child to the emergency room, they have in mind that they wish somebody would take this child for a while. It is not an unknown idea in a parent's mind. Very often we disagree with that and try to find some other solution to the problem.



JUDGE BRODERICK: In such a situation where you don't disagree, is it your opinion that error has been made in your experience in admitting such a child to in-patient treatment?

THE WITNESS: Well, I thought about that question. It is difficult to answer because presumably (75) if I reach the decision, I don't know whether the error is being made. I presume it is not being made and unless for some reason someone else looks into the situation and disagrees with me at that instance, there is no real way of checking on that.

What I have seen is that many times within a day or two, a child is quite different and even though perhaps at that particular moment in the emergency room, it was necessary to place some restraints on that child and that is one of the problems.

I think psychiatrists make good diagnoses, but their prediction of behavior holds up for a short period of time and it has to be reviewed.

There is one instance that comes to mind of a child that was hospitalized and this was a personal patient of mine when I was in training in the hospital who had been in the hospital for several months and I wanted to discharge this child.

As a matter of fact, not even home, but to a residential treatment center and the mother wanted the child to stay in the hospital and refused to give the child clothes. I sent the police to the home to pick up the clothes.

JUDGE BRODERICK: In that situation you had no problem except for the lack of cooperation of getting (76) the child out of the hospital.

I have no further questions.

MR. FERLEGER: Thank you, Doctor.

(Witness leaves stand.)

(77) MR. FERLEGER: Plaintiffs call Michael Ingall to the stand, please.

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MICHAEL INGALL, sworn.

THE CLERK: Would you state your full name?

THE WITNESS: Michael A. Ingall.

THE CLERK: Thank you, be seated.

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*Direct Examination*

BY MR. FERLEGER:

Q. Doctor, what is your occupation?

A. I am a psychiatrist.

Q. Would you state for the record your current affiliations?

A. I am the medical director of the Providence Health Center in Providence, Rhode Island, which is a mental health out-patient unit.

I am also clinical professor of psychiatry at Brown University School of Medicine.

Q. Would you please state your background as briefly as you can in psychiatry especially with reference to children and legal matters?



A. I am a graduate of the Chicago Medical School. I did three years of residency at Boston University Medical Center, one year of which was a Fellowship in child psychiatry which was spent at various psychiatric (78) facilities in Boston, one of which was the Roxbury District Court Clinic, where I served as a consultant to the Court, seeking alternatives to in-patient institutionalization or jail for people who were before the Court on drug related offenses.

Most of them were adolescents and we sought community based out-patient treatment or residential treatment in a half-way house for them.

Q. Doctor, have you been the recipient of any awards or honors in your field?

A. I received from the American Psychiatric Association a Faulk Fellowship, which is an honor.

I am a member of Alpha Omega Alpha, which is an honorary medical fraternity.

Q. Are you certified by the American Board of Psychiatry and Neurology?

A. Yes, in psychiatry.

Q. Where are you licensed to practice medicine?

A. Rhode Island and Massachusetts.

Q. Doctor, with reference to your Curriculum Vitae which I will show you and this is marked plaintiffs' Exhibit 6—

MR. FERLEGER: I apologize. I have to call him out of order because of his airplane schedule.

Q. —is this a summary of your qualifications and (79) background?

A. Yes, it is.

MR. FERLEGER: Do you have any questions on qualifications?

MR. ROTH: No, I don't.

MR. FERLEGER: May I proceed, your Honor?

JUDGE GIBBONS: Yes.

MR. FERLEGER: Thank you.

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*Continued Direct Examination*

BY MR. FERLEGER:

Q. Dr. Ingall, I wonder if you could discuss just briefly the general question of the sources from which children's emotional difficulties arise and what the relationship is between that and the family structure that Mr. Roth has been talking about?

A. In my opinion, most of the children whom I see, most of the young children and adolescents whom I see, what emotional problems they have usually is a function of intrafamilial problems, that the problems of the children are manifestations of problems that go on within the family.

There are occasional psychiatric problems that tend to be psychoneurological in character which are perhaps not stemming from intrafamilial conflict, but which in and of themselves often give rise to intrafamilial conflict because of disagreement of the management (80) of the child and home.

Q. Is it your opinion, then, that it is the family that has problems or is it usually the presenting child that has the problems?



A. Well, I would say with most of the kids and adolescents that we see at our clinic, most of them are brought by parents or come with parents. Usually, they come at the suggestion of a school or court, the presenting complaint being not that of the child, but of the parents, saying, "My child is doing such and such. I would like you please to fix him."

Q. In those situations, can you explain why the child, rather than another member of the family would be the one who would be identified in the role of the patient?

A. I think it is because children are little and are in a subordinate position with regard to their parents.

If a parent decides the kid is going to go to a psychiatrist or is going to go to a hospital, the child's objection does not carry the weight that an adult of equal stature would carry. It is much easier to hospitalize a child if you are an adult than it is your brother.

Q. In those situations, Doctor, with what frequency have you found that parents suffer from some emotional illness as well as the children they seek to be put into (81) treatment?

A. Frequently and—

Q. You may explain.

A. As I said before, if we have a child or adolescent who is presenting in this way, one of the early goals in treatment we have is to see the family, either to go as a family unit if things are not too chaotic or at least to see the parents separately from the child, in order to get the focus of the kid as a scapegoat as to what we see as intrafamilial problems to try and get the family working together.

Even if the family says, "You have a problem; how can we help," that is better than saying "You have a problem; go get it fixed."

Q. Do I understand that you said that the child is at times the "scapegoat" of the family's problems?

A. Yes, it's a strong word. I don't use it myself.

Q. Doctor, I wonder if you could give us your opinion with regard to whether or not in a non-emergency situation, there ought to be a judicial hearing prior to the commitment of a child to an in-patient mental institution?

A. I think there should be. I think particularly so in the case of a child. An adult or an older adolescent has the capacity and the maturity to make his own case, either to the admitting psychiatrist at a state hospital (82) or to an examining psychiatrist at another facility and he can convince, perhaps, that psychiatrist that he should not be hospitalized. He can say, "Look, they want to put me in the hospital because my mother wants to go out every night." He can say, "Father wants to put me in the hospital because he is jealous of me."

He can make a convincing case for himself. A younger child often does not have that capacity and he may not be able to say, "Look, okay, I need treatment, let me go on an out-patient basis." He may not know what resources are available to him as an alternative.

Q. What function do you think the hearing could have in that kind of situation?

A. I think in that situation the child would have an advocate who was clearly representing him who would explore with experts, if necessary, alternatives to hospitalization and would review the need for hospitalization, which is for me a last resort.



Q. Can you give us your opinion on whether or not you feel there would be any trauma or any adverse psychological effect on a child of having such a hearing in the child's behalf?

A. I think there would not. I think if the situation is such that a hearing must be arrived at, that the parents and child are in such conflict, that this must (83) ensue, that there already is severe parent-child conflict and disruption between the family and that such a hearing can certainly do no further harm.

I don't think it is harmful to a kid to hear what a psychiatrist or anyone else has to say about him and I don't think it is harmful to hear diagnostic terms bandied about.

Q. In that situation that you are describing where there is family conflict or at least, disagreement, do you feel that the parents are in a position to judge the best interests of their child and what kinds of treatment the child ought to obtain?

A. Well, even when there is family conflict, often, it is the case that parents do want what is best for the child. I think it is an unusual circumstance when parents are really adversaries of the child.

Even however when parents want what is best for their child, sometimes their judgment because of their intimate involvement with the situation and very emotional strong feelings that they have about their kids which is natural, often then, their judgment is not the most objective.

Q. Are there occasions—

MR. FERLEGER: Strike that.

Q. In the context of a family that is seeking (84) institutionalization for a child, have you had any experience with misinterpretations of a child's behavior by members of the family or by psychiatrists that the family has sought out?

A. I got hung up on the word "institutionalization" and that means something different than the word "hospital".

Can I elaborate on that?

Q. Yes.

A. For me, institutionalization has a negative connotation. There are many institutions, a college is an institution, this Court is an institution, a psychiatric hospital is an institution. When we talk about the negative effects of institutionalization and we usually talk about the negative effects rather than the positive effects of institutionalization, we are talking about a situation which is usually a detrimental one, so I am opposed to institutionalization, voluntary or involuntary, and I am very much for hospitalization when adequate treatment is available and I realize it is not a right-to-treatment suit, but I think there is a difference.

Q. When a child is to be placed possibly in an inpatient facility which may be detrimental or may be positive, in your terms, are there problems with the psychiatrist, that they are relying on simply the parents for the factual information upon which their decision is (85) based?

A. Sure, everything that you hear from a patient or his family is given with a bias. We all try to present ourselves in the best light we can.

Q. Do you feel that you, as a psychiatrist or a judicial officer at some sort of hearing should be the person to resolve those factual conflicts?



A. Well, if you are talking about strict questions of fact, you know, did the child do this at such and such a date—

Q. Yes.

A. —Well, I think that the legal profession is much more adept at dealing with objective fact than the psychiatric profession, although sometimes I think objective fact is not as relevant as subjective emotions.

Q. Now, have you had any experience in working with Courts in terms of giving your advice on the medical end after the Court has determined the legal questions?

A. After the Court has determined the legal questions?

Q. With regard to a need for treatment.

Have you had any experience in providing input into what happens therapeutically to the subject?

A. My experience at the Roxbury District Court, my consultation with the patient or client occurred after an indictment, but before sentencing, so I would confer (86) with the judge prior to his sentencing of the client or defendant and then, the judge would decide whether or not to make treatment in the community an alternative to incarceration.

Q. Will you explain, Dr. Ingall, the reasons that you think as a psychiatrist, that it is important for there to be a hearing with an advocate representing the child's interests?

A. Well, if I have to treat someone who is involuntarily committed to me, that is possible. If I, however, am the one who, in the eyes of my patient, is incarcerating him within a hospital, then, I become (a) therapist, and (b) also jailer, and that is a confusing role for me and the

patient and it makes treating the patient difficult because it heightens the ambivalence to me.

I have treated patients who were submitted to me and the Court would say, "You have to go see the shrink or you go to jail," and the kid would come in and see me and I'd say, "Why are you here?" and he would say, "The judge said I have to be here."

I would say, "That's a sad situation and we have to meet together, so let's make the best of it," and we would form a therapeutic alliance in that way.

Q. And you feel it is difficult to form such an alliance if the psychiatrist is the one who certifies (87) the need of hospitalization for the patient as in the state's regulations?

A. Unquestionably.

Q. Dr. Ingall, in the non-emergency situation where necessity for hearing might involve some delay of a week or two, perhaps, can you see any reasons, number one, that the delay should be so terrible that we shouldn't allow such a delay or, two, do you see any advantages to such a delay?

A. If it is a question of an emergency commitment where imminently a child is in danger of hurting himself or others. There should be provisions as there are in this and in most states for involuntary hospitalizations.

Q. In a non-emergency situation?

A. In a non-emergency situation I don't see any harm and I think there are advantages to a delay.

Children, as we all know, have a tremendous capacity to recover, to improve and to change.

You know, all of us know and perhaps remember ourselves when we were adolescents, one day you are



in love with a girl and you know, she is the end of the world and she won't have you and you are going to die. You are going to go out and kill yourself and the next day you meet somebody else and you are on top of the world.

Children are very fluid. Also medically, (88) a child admitted to a hospital or a child on an out-patient basis who is medically ill, may look as though they are on death's door and indeed be on death's door one day and the following day become completely well, running around.

Saturday, my daughter was home in bed, vomiting, pale, feeling awful, and Sunday morning she was running around outside.

Q. Do you think in terms of the psychiatrically ill juvenile, that the delay might help things? Is that what your testimony is?

A. Yes, I think hospitalization is a very serious step to take with an adolescent, child or an adult and if there is a waiting period in a non-emergency situation that things can change so by the time the hearing comes around, there is no need for the hearing. All are agreed that hospitalization is or perhaps things—or perhaps hospitalization is not needed or perhaps the situation deteriorates where people decide, the child included, he needs to be in the hospital.

Q. Can you please explain why you would wish to make a distinction between parents taking their children for treatment in an in-patient psychiatric institution as opposed to treatment by a neurologist or by a physician for a physical problem along some other basis?

(89) Why is a mental hospital such a different place?

A. A mental hospital is a different place, because there's stigma attached to it and because depending on the hospital, it can be a dangerous place.

There can be situations in which a child is exposed to other patients who are dangerous to him and if there is not sufficient staffing within the hospital to insure the safety of all, it can be a dangerous place.

Q. Is there any other way in which an institution can be dangerous?

A. There was an article in the Sunday Times yesterday about kids who were in a facility, who were being raped and extorted and they shouldn't have been there.

Q. Now, Doctor, with reference to the state's regulations which were adopted subsequent to the institution of this lawsuit and which provides for the possibility of a hearing for those 13 through 18 year olds after commitment, can you give us your opinion on whether or not such a proposed commitment hearing can be harmful to the psychological well-being of the child?

A. Whether the hearing can be harmful?

Q. Whether having the hearing after somebody is already in the institution might be detrimental.

(90) A. It is far more preferable to have the hearing before-hand.

Q. Why?

A. Because you may avoid the necessity of hospitalization in the first place.

Q. With regard to children who are, let's say, under the age of 10 or 11 or 12, who I think we can all agree might not be able to identify their need for an attorney or for a hearing, do you think there would be any benefits to a prior hearing with regard to those children?



A. Yes, I think if a child has a serious objection to hospitalization which cannot be overcome by talking with his parents and with a doctor on the outside, that that child is entitled to legal representation at a hearing, providing it is not an emergency situation, prior to the decision to hospitalize him.

Q. Do you feel that such a hearing or provision of Counsel would interfere with the treatment of juveniles by psychiatrists?

A. A hearing beforehand?

Q. Yes.

A. You mean if the child is later admitted to a hospital?

Q. That's right.

A. Would it interfere?

(91) Q. Yes.

A. No, I can't see that it would.

Q. Do you feel that such a hearing would be a substantial hindrance to the relationship between the parents and the child?

A. No, I do not.

MR. FERLEGER: Mr. Roth, your witness.

MR. ROTH: Thank you.

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*Cross-Examination*

BY MR. ROTH:

Q. From your testimony, I understand that you are opposed to hospitalization until every other avenue has been explored; is that correct?

A. Generally, yes.

Q. Do you feel—let me ask you, are you familiar with our procedures? Were you in court today when Dr.

Kandler referred to "Annex 'a' ", about the additional safeguards?

A. Yes.

Q. Are you aware of the two-step procedures used in Pennsylvania?

A. For what?

Q. For the possible institutionalization of a child.

A. You mean under Annex "a"?

Q. Yes.

(92) A. My understanding is that a child must be taken to an outside facility, outside the hospital, certified there and certified at the hospital to be admitted and then on an uncertain date after admission, has a right to a hearing.

Q. Well, that part is true, but basically, I am just familiarizing you with it because I'd like to ask you a question about it.

The child is taken to a recognized agency or a private psychiatrist and a psychiatrist makes a recommendation, for, if you will, institutionalization and consequently, the recommendation, along with the parent and child, arrives at the institution and an individual examination is conducted and if that examination corroborates, agrees with the first, then, the child is institutionalized or recommendation is made for the parent and the parent may or may not institutionalize the child and once the child, age 13 or older, objects, the child is provided with Counsel and a hearing.

Now, you have stated and I don't think the Commonwealth is at all at odds with the statement, that hospitalization is a last resort.

Would it not be your professional opinion that based on this procedure, that the psychiatrist generally would



seek some form of treatment, other than (93) institutionalization?

A. Not necessarily.

Psychiatrists vary in their opinions as to the need for hospitalization. There are some psychiatrists who like to hospitalize most of their patients initially for a diagnostic workup.

I disagree with that. There is also a situation where a poorly funded, poorly staffed clinic in the community may be overwhelmed with the number of cases asked to treat. And it is a fact they have too many cases and the clinic may say to the parent who comes in, "Sure, as long as you don't bring them in," and they will acquiesce.

Q. Let's assume you have a clinic overworked and that is so because there are no other modalities of treatment for the child, so they recommend institutionalization and the director of that institutional place has an individual examination conducted, do you think the results of that examination will be the same as the first?

A. In the situation you outline where there is no alternative except institutionalize, I think that carrying with it the bad connotations that it carries is probably worse than leaving the child in the community.

Q. I inform you this is a case as to the challenge of the type of treatment.

(94) Bearing that in mind, the question remains, if no other form of treatment is available, whether it is in a county in Pennsylvania or in Wisconsin or where-have-you and the only way to provide treatment for that child would be institutionalization, would you be opposed to it?

A. Yes, I would, on the basis that two psychiatrists feel the child is mentally ill and that other resources being

unavailable, hospitalization must be resorted to and the child objects, then I think that child has a right to object and a right to a hearing and a right to Counsel to state that objection.

Q. Let's follow that out.

Assuming all those facts were as we have discussed, where there be no other form of treatment in that particular area and that the child were afforded a hearing and it was determined that the child does need a method of treatment which is unavailable and that form of treatment could be met at an institution, would you object to a judge finding or holding that a person should be institutionalized for that type of treatment?

A. If psychiatrists feel that only in a state institution is the form of treatment that is available that the child needs and the child objects and the case comes to a hearing, then I would hope that at that hearing it would be decided that despite the objections of the child, (95) he would have to go to that institution.

I am not opposed to involuntary hospitalization. I think there have to be safeguards against it, however.

Q. You don't feel those safeguards are available by permitting a hearing after the child has been committed?

A. That is one level of safeguard. I believe it would be better to have the hearing beforehand.

Q. You prefer a hearing beforehand but you are not objecting to one after?

A. I think anyone who is hospitalized involuntarily is entitled to hearings at various stages, be it a child or an adult.



Q. Now, you have indicated that parents who necessarily come to your facility are not in the best ways to assess the problems of their children; is that correct?

A. Some.

Q. Some?

A. Some parents.

Q. Don't you think the mere aspect of the fact that a parent brought his or her child to you presumes that the parent is acting in the best interest of seeking treatment for the child?

A. That is not always the case.

I have had a very significant number of (96) patients who have come to my clinic which is a sizeable one, where the purpose of bringing the child to treatment has been to accuse him, to punish him, to separate him from the home. The motivation is not always good. Usually it is, but not always.

Q. And, in those situations, how do you react; what do you recommend?

A. I recommend alternatives to hospitalization. I will recommend either seeing the family together on an out-patient basis as a family unit. I will recommend seeing the kid on an individual basis and seeing the parents separately, if they will agree.

Q. So, in other words, Doctor, wouldn't it be very difficult, again, referring to our regulations, that if someone came to you and you did not recommend institutionalization, it is going to be very difficult for that parent in order to put that child into the institution, wouldn't that in effect occur in Pennsylvania?

A. Could you repeat that?

Q. If we are using the two-step process and the parent comes to you and you feel the motivation of the par-

ent is not correct, and you do not recommend institutionalization, the parent won't be able to have the child admitted?

A. There are plenty of psychiatrists around, the parent can seek alternate opinions.

(97) Q. The parent would begin to doctor-shop, is that what you are saying?

A. Possibly. We had had within the past week a mother bring a kid to the clinic who had originally been to child welfare services, wanting her child placed, because of his behavior, in a sort of state institution for abandoned children; I am not sure what the equivalent would be here, but it is not a psychiatric institution.

If a family goes in the hospital and the child is left without care, a foster—a state institutional home for kids. The family was evaluated by that service and the kid was felt to be not in need of shelter services. In that case, the mother came to our clinic, simply saying she would like her kid put in a psychiatric hospital because she is tired and she can't take care of him. We got her some help.

We did not hospitalize the kid, not to punish him, just because she could not take care of him and she was labeling the kid as emotionally disturbed to get him out of the home.

It was for his benefit, really, she couldn't take care of him, but we did give her support with a homemaker and visiting nurse coming in and rallying her family around her.

So the kid did not have to be put in a (98) state institution.

Q. The best interest of the child in that situation was served, was it not?



A. Yes, without institutionalization, even though that is what was originally requested and we were able to resolve it.

Q. And the parent sought help from your clinic?

A. Yes, and we didn't need the hearing.

Q. What would happen in your opinion, Doctor, if a hearing were provided and the juvenile had an attorney and the attorney looks at all the facts and he decided to capitulate and decides that it really would not be in the best interest of his client to have a hearing; that he is convinced?

A. It would be in the best interest of his—

Q. "I have reviewed all the facts and evaluations of the psychiatrist who my client has had"—is not too certain whether he should go to a hearing. What would you do in that situation?

MR. FERLEGER: That is not within his competence if an attorney decides to waive a hearing, if the Court grants attorneys to waive such a hearing.

JUDGE GIBBONS: Sustained.

Q. Would you define what you know to be an emergency situation as versus a non-emergency situation?

(99) A. An emergency situation is one where a patient is imminently dangerous to himself or others as a result of mental illness, whatever that is.

Q. And a non-emergency situation?

A. Is one in which that is not the case; in which those criteria are not fulfilled.

Q. Could the modality of treatment still be essential for a non-emergency patient as immediate as for one who is, say, dangerous to himself or others?

A. You will have to say it again. I'm sorry.

Q. For example, could a person who is a non-emergency commitment require help as quickly as one who is a candidate for an emergency situation?

A. As I undestand your question, you are asking, is a non-emergency situation equally an emergency as an emergency situation?

Q. In essence, yes, in terms of treatment or hospitalization.

A. The answer is no.

Q. Let me ask you this:

Can a patient—can a prospective applicant, because he has to go through a judicial process, be delayed to such a length of time that what was a non-emergency situation becomes an emergency situation, where no one becomes fully aware of it?

(100) A. Patients die with their rights on and with their rights off. Patients die who are in treatment and patients die who are out of treatment.

We psychiatrists as a class, are pretty good at formulating diagnoses. We are pretty good about dealing with people about how they feel; we are pretty good in listening to them. We are bad in predicting what they are going to do. People suicide and kill others who are in psychiatric treatment. That is despite efforts of psychiatric treatment.

To lock people in psychiatric hospitals on the vague prediction they may do harm to themselves in some uncertain way or some uncertain time is a severe abridgement of their civil rights.

Q. Is it your opinion that a hearing should be provided only for the juvenile who objects, or for any person, you know, 18 years of age and younger?

A. Only to the juvenile who objects.



Q. So, in other words, if you have a juvenile who cannot even formulate an idea, who is so removed, if you will, then you feel it would be in his best interests to allow the parent to admit him, notwithstanding the fact that he has not objected?

A. If the child is unable to object?

Q. He is unable to object.

(101) I am sure you have seen—well, I'm sorry.

He is unable to object.

A. Well, at what age?

Q. Let us say, it is irrespective of the age. As long as he is in the age group.

A. Are you implying the child is unable to object because of some emotional or mental impairment?

Q. As you may know, the statute addresses itself to not only mentally disabled, but mentally retarded.

A. Yes.

Q. So if you have a severe mentally retarded person—

A. If you have someone who is that severely mentally affected that he can't speak for himself when asked if he wants an attorney or what his rights are, if he can't respond to that at all, I think chances are, he requires inpatient treatment, if someone else thinks he does on the outside.

Q. What about a person that is so out of touch with reality, that one of their behavior modes is objecting to everything? That their objection is really not an objection as you or I would know it, but it is just a form of their behavior pattern; do you feel that a hearing should be provided in that instance?

A. I can't picture the kind of person that you are talking about. Someone who objects; when you say yes, (102) he says no?

Q. Yes.

A. Someone who is just obstinate?

Q. Correct.

A. Well, I don't think that is a ground to commit someone to a hospital.

Q. I am not saying that is the grounds.

I am saying that is one of the elements of his behavior and assuming other conditions of his behavior warrant admission into a hospital, do you feel in that situation the person ought to be afforded a hearing?

A. Yes.

Q. Why?

A. Because he is a human being who has rights and if he objects to being hospitalized and he is not in danger of harming himself and others imminently, that he has a right not to be locked up in a hospital.

Q. So, it is your feeling and opinion that a hearing should be provided to anyone prior to their admission into a facility where they object to that admission; is that correct? Notwithstanding the fact that to object may be valid or invalid.

A. That anyone who does not want to be hospitalized on a non-emergency situation, we are talking about?

(103) Q. Yes.

A. That if someone does not want to be hospitalized, sure, I think he should have a hearing.

JUDGE GIBBONS: Regardless of age?

THE WITNESS: Regardless of age.



Q. Are hearings provided in Rhode Island?

A. Under the current mental health law, after hospitalization, but not before.

JUDGE GIBBONS: Does Rhode Island have any provision for juveniles voluntarily admitting themselves without parental involvement?

THE WITNESS: I don't know.

In our clinic we will see juveniles without parental consent and most of the time we will try to get parental involvement, if only for consent later.

Q. Does your clinic provide in-patient treatment?

A. No, we do not.

Q. Have you ever been associated with a state institution?

A. I have not directly worked for a state institution, but I am currently associated with the state institutions in that I teach there and have rather extensive liaison with them, because that hospital has a large course of referrals to my clinic, which is a public clinic. So I am quite familiar with the situation in an in-patient (104) state hospital facility.

Q. There's been some discussion with the prior witness about juveniles calling for help; do you think there's anything to the fact that a juvenile is often objecting because he is seeking help?

A. I don't think a juvenile objecting to hospitalization is a plea to help. It is possible you might interpret that behavior that brought the child to a hospital, psychiatrist or a hearing, like stealing or using dope; you might interpret that, if you wish, as a plea for help, but refusal. I don't see as a plea for help, no.

Q. So, that it is true that the key to diagnosis would be not the subjective symptoms which the patient reports, but the acting-up behavior?

A. That can be viewed as a symptom.

Q. Aren't juveniles reluctant to provide that behavior?

A. They do that with a great deal of zeal, from my experience and they are less happy to report they are depressed.

MR. ROTH: If it pleases the Court I would like Mr. Moss who is associated with me to continue with some questions.

JUDGE GIBBONS: All right, proceed, Mr. Moss.

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*Continued Cross-Examination*

BY MR. MOSS:

(105) Q. Dr. Ingall, you stated in your direct examination by Mr. Ferleger that you were opposed to hospitalization and institutionalization because you feel other alternatives are not explored and you feel for that reason the child should have a prior hearing, because he cannot convince the medical people treating him that he should be treated in some other alternative.

Do you have any evidence that indicates that other avenues or other alternatives are not explored by the medical people treating the child?

A. I know of circumstances in which people have been referred for hospitalization by virtue of the fact that the doctor whom they saw was too busy to make a complete evaluation of the situation and felt that it would be



easier to admit the child to an in-patient facility, where other staff, besides himself would be able to do this.

Q. You know that through a personal experience?

A. Yes, I do.

Q. Do you feel that having a prior hearing is the only route to making these other alternatives?

A. I think more community alternatives need to be made available. I don't think the hearing is the end all. No.

Q. Cannot this function and isn't this function done by the other social agencies involved with the child and isn't it true that other alternatives are explored?

(106) A. Explored?

Q. Yes.

A. Often that is the case.

Q. You stated that—

A. I think we are talking here about the exception, rather than the rule. I don't see every kid for whom hospitalization is proposed as coming before a hearing.

Q. You stated that there is no trauma from a prior hearing because there is already a disruption in the family patterns.

Is that an assumption on your part and do you have any figures which would show the percentage of children admitted from homes where the family has been disrupted?

A. You mean do I have proof that a hearing is not—

Q. Have you read any studies or have you done any studies of your own which would indicate that in most situations, the family has been—the family patterns have been disrupted?

A. Yes, I have read studies—they have been disrupted by hospitalization or beforehand.

Q. You stated that there is no trauma which develops from a prior hearing, because the family patterns have already been disrupted, right, which is an assumption, if I understand your response, is an assumption on your (107) part, then, that in all situations in which an adolescent is in need of hospitalization or reaches the point that he is in need of acute psychiatric care, that the family pattern has been disrupted; that there is a break in the family pattern.

Do you have any knowledge as to any studies having been done or any figures which support this?

A. Figures—I am sorry, you mean that kids who are in hospitals come from families where there is emotional disturbance among the family?

Q. That the family pattern has been disrupted, to use your term.

A. Has been disruptive?

MR. FERLEGER: Disrupted.

A. I know from personal experience and textbooks and articles that I have read, there is a good deal of evidence to show that kids who are in psychiatric hospitals come from families where there has been familial disruption.

Q. You don't know whether there's been disruption which has taken place prior to hospitalization?

A. Yes, prior to hospitalization.

Q. Prior to the hospitalization?

A. Yes.

Q. You stated that sometimes, by the time the hearing would come around, it would not be needed.

(108) What percentages of these cases have you seen?



A. We don't have a hearing system where I work prior to hospitalizations, so I can't tell you what percentage.

Q. What about the proposed hospitalization hearing situation? You testified to something in regards to the hearing not being needed.

Do you recall what you stated?

A. Yes, I think I said that if there is a delay between the time hospitalization is proposed and a hearing takes place, that it may be if that interim between the proposal and the hearing when a decision will be made, that the hearing—that family communication is enhanced to the point that they can resolve that hospitalization is not needed and that alternative treatment can be used or alternatively the situation may deteriorate where all involved feel that hospitalization—either the child agrees that hospitalization is needed or else the situation reaches emergency proportions, in which case emergency commitment can be applied.

Q. In a situation where the hearing is not needed and actually what has taken place is that the wounds of the illness have healed themselves through time.

A. I wouldn't go to that extent. I think if you have reached that kind of situation, things are not going to be (109) better forever after, simply because hospitalization is going to be avoided.

Alternative treatment is often very useful.

Q. You were asked on direct examination, that if a proposed commitment hearing were held, would it be harmful to the child and you stated, you feel that it is better to have a hearing before.

I would like to ask you that question again and respecting your desires of wanting the hearing prior to commitment, can you tell me whether you feel in your professional opinion whether a proposed commitment hearing would have any harmful effects?

A. No, I can't see that it would.

Q. You did state it would not hinder the treatment process if the child is represented by Counsel prior to the commitment; that it would not hinder the relationship between parent and child.

Can you tell me why?

A. I can't see any way in which it would hinder it. You are implying that it would.

Q. I am just asking you for your opinion and you stated on direct—

A. I don't think it would be harmful.

Q. You have no reasons why?

A. Yes, it would not be harmful.

(110) Q. As a psychiatrist—

A. It is not harmful for a child to meet with an attorney or guidance counsellor working on his behalf. It can be beneficial.

Why should it be harmful to meet with a lawyer? They are not so bad people.

Q. You are a therapist and in private practice and treating a child and it reaches the stage where you feel the child needs to be hospitalized and the child does not accept your suggestion, you then take the next steps to have him hospitalized and the jurisdiction that you happen to be in there is a statute that says that there must be a prior hearing.



The only person who has worked with the child and who is aware of the child's illness is you, the therapist, and you are the only person who can testify to the Court what is wrong with the child and why he has to be institutionalized.

The child is in the courtroom and you are there testifying. Are you not becoming an adversary to the child?

A. In a sense, yes, you are right.

In a sense, that might be disruptive to our treatment relationship. However, more disruptive would it be if I didn't have a lawyer representing that (111) child and I, myself, by picking up a pen, signed a paper and said, "Too bad, you are going whether you want to or not," and it was all on me.

That would be much more disruptive.

MR. MOSS: I have no further question.

MR. ROTH: No further question.

MR. FERLEGER: No further question, your Honor.

JUDGE GIBBONS: Thank you, Doctor.

We will recess until two o'clock.

(Whereupon, at 1:00 o'clock p.m., a recess was taken.)

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Afternoon Session

(Whereupon, at 2:00 o'clock, p.m. all Counsel and parties being present, the following transpired in open Court.)

MR. FERLEGER: Your Honors, at the end of Dr. Ingall's testimony, I neglected to move for the admission of his Curriculum Vitae.

JUDGE GIBBONS: It is admitted.

JUDGE HUYETT: Which Exhibit is that?

MR. FERLEGER: Number 6.

(Whereupon, the Curriculum Vitae of Dr. Michael A. Ingall was marked plaintiffs' Exhibit 6 in evidence as of this date.)

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(112) ELI CHARLES MESSINGER, Sworn.

THE CLERK: Would you state your full name?

THE WITNESS: Eli Charles Messinger.

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*Direct Examination*

BY MR. FERLEGER:

Q. Doctor, what is your occupation?

A. I am a psychiatrist, a child and general psychiatrist.

Q. What is your present affiliation or appointment?

A. I am assistant attending at St. Luke's Hospital Center, New York City.

I am a clinical instructor in psychiatry at Columbia Medical School College of Physicians and Surgeons and I am currently employed at the Neighborhood Health Service program.

This is a federally funded comprehensive health care program in Manhattan. It has a mental health unit of which I am acting psychiatric director.



I also have a small private practice and work with both children and adults.

Q. What has been just generally your experience in terms of years and type of treatment in child psychiatry?

A. I am a trained child psychiatrist. I had two years of child psychiatry fellowship at Bronx Municipal Hospital Center in the early 1960's.

(113) The two years were separated by two years in the Public Health Service in which I served as psychiatrist and chief medical officer at a federal reformatory in Oklahoma.

There, I worked with youthful offenders.

I have been in the practice of child psychiatry since 1965 and all my salaried positions have been in this area.

Q. Dr. Messinger, are you certified by the American Board of Psychiatry and Neurology?

A. Yes.

Q. When did that certification occur?

A. In 1966.

Q. And are you also certified in child psychiatry?

A. Yes, in 1970.

MR. FERLEGER: Any question, Mr. Roth, as to qualifications?

MR. ROTH: No question.

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*Continued Direct Examination*

BY MR. FERLEGER:

Q. Dr. Messinger, one brief thing with regard to your qualifications, have you given any talks or written

any papers with regard to the relationship between law or legal rights and psychiatry?

A. Yes, I have.

I have delivered a talk to the American (114) Orthopsychiatric Association on some interconnections between the legal and psychiatric systems.

I have written an article for the Journal of Medical Probation on the psychiatric treatment of the youthful offender.

Q. Doctor, can you describe to the Court what age children you have treated and what institutional or non-institutional contacts you have had?

A. My experience with in-patient psychiatric work with adolescents and younger children was confined to the years 1960 through '65, with the two years in the Public Health Service and there, I worked with children of all ages, down to at times, three or four, who had to be hospitalized and with adolescents who were in the hospital, too.

Since that time, I have treated children and adolescents of all ages, but not in an in-patient setting.

Q. Does your facility which you are presently psychiatric director for, ever refer children to in-patient settings?

A. Yes, but very rarely.

Q. Dr. Messinger, can you please describe the current orientation in child psychiatry regarding the role of the family and the family structure and the difficulties (115) that children may have?

A. Yes, I believe that there is wide-spread agreement in the field of psychiatry, as well as the other mental health professions, social work and psychology, that the



problems of children and the problems of their parents are inextricably connected; that the family should be viewed in many instances as the locus of pathology or trouble; that it is impossible to understand the symptoms and behavior of any one member of the family without understanding its role in the family in maintaining the family equilibrium; that symptoms are often an expression, be it a distorted expression—a distorted attempt to communicate, make demands on, ask help from, seek the support of other members of the family.

I think that it is unwise to think in terms of blame of either the parents or the children, but that it is wise and necessary to view the interrelations between the problems of the designated parent—designated patient, excuse me. Certainly, if that patient is a child or adolescent, to see those problems in terms of the whole family structure.

Q. Does it occur, Dr. Messinger, in families which present a child for psychiatric treatment that the families or parents, for example, in families might also be in need of psychiatric care?

(116) A. Very often, that is the case and this is not a current fad in psychiatric thinking.

It really goes back a full half century to the beginnings of the child guidance movement which had its origins in psychiatry primarily and here in Philadelphia, and this was recognized in the very structure of the child guidance clinics which were organized so that the psychiatrist—usually a psychiatrist who worked with a disturbed child, had as an ally in therapy the social worker who did counseling or case work with the parents.

Q. Dr. Messinger, in terms of this family orientation of psychiatry, do you have any opinion as to whether

or not an institution, such as a state mental hospital or a similar facility would be more or less likely to involve the family than a community facility?

A. In my experience, it is inevitable, that an institutional setting pays less attention to family pathology and family dynamics, than does a community facility.

Q. Why would that be?

A. I think that there are a number of reasons, starting from the most obvious. Many of them are physically separate from where the family resides and perhaps, at best, the family can afford to take a bus trip or a train trip to a facility in the countryside maybe once a week (117) or once a month.

Sometimes, the treating psychiatrist or social worker isn't there on the day that the parent who is taking time off from work, for example, or coming on a weekend. The treating psychiatrist, he isn't there to have an interview with that person, but there are other considerations which are less tangible and that has to do with orientation and I think the orientation of institutions tends to be that the designated patient is the sick one, that the pathology resides within that individual and they tend to overlook, or at least under-emphasize the ways that those problems—under-emphasize the interplay between the designated patient's difficulties and those of the rest of the family.

I might add that this family orientation to psychological difficulties has been one of the major trends in the last 10 or 20 years.

Again, Philadelphia happens to be a center of research and treatment in this area and the modality of treatment which has emerged from this orientation is called conjoint family therapy. That is, all members of the family



are involved, usually with the same therapist and in the same room at the same time in working out their problems

Q. Is that because the family is seen as needing help (118) as a whole or is the family just there to help with the child's problems?

A. Both. I mean, even if you have a disturbed youngster who has a disturbance onto himself, so to speak, the family does need assistance in its coping with that. Almost inevitably.

Q. Dr. Messinger, in the light of this situation, do you feel that parents are always in a position to judge what is best for their children in terms of psychiatric care?

A. I think that when a parent or when parents knock on the door of a social agency or a psychiatric facility and say in effect, "Do something," whether the "do something" is give medication, put him in the hospital, do some tests, they are saying that the problem is serious enough so that they can no longer cope with it; that whatever their internal resources, the stress and strain is beyond them.

That is, I think, a role that parents should take. I think that is a very different question from what is the best kind of treatment approach once one has identified that either a child or adolescent or a family is in trouble.

Q. Dr. Messinger, could you describe in terms of its effect and its nature the differences between institutional (119) treatment of psychiatric problems as opposed to community facilities?

In other words, why might there be a desire or a belief on your part as a psychiatrist that institutional care might merit different procedures than non-institutional care?

A. Let me try to answer that first by citing the advantages to a practicing child psychiatrist of working in a community facility and obviously in my own professional work, that is where I have chosen to be and then, to talk about some of the disadvantages or even dangers of institutionalization.

The advantages of working in a community facility are that one can readily be in touch with the child's family, with the child's school, with interested relatives or friends, with a variety of community leaders or helpers.

For example, a counsellor in an after-school recreation center. Even a store-keeper who has a friendly relationship with a teenager who most other people can't stomach, but one has access to what we call in psychiatry, "the social support system," and can bring our weight to bear on strengthening that social support system.

In practical terms, the institution that (120) usually blows the whistle on trouble for a child is the school, because of truancy, academic failure, misbehavior in the school.

If one works in a community facility and sees the child there, then one can—and I do these things—go to the school and talk with the classroom teacher, talk with the guidance counsellor and principal and if necessary make arrangements for transfer to another classroom, transfer to another school or transfer to a specialized school that will handle a youngster with whatever problems they might turn out to have.

Some other advantages—well, let me go to some of the disadvantages of institutionalization.

One is rooting the child out of the family and community, starting with the situation of excluding the child



from the family. I am not saying that that is never necessary. In extreme cases, it is. However, because the child's symptoms are immersed with the problems of the family, if there are going to be real changes in that child, there have to be concomitant changes in the family.

If the child remains at home for treatment, then one can work with both sides of the equation together. If a child goes to a state hospital, for example, for three months and then returns considerably improved, the (121) likelihood is that because of unresolved difficulties with the family, there will be a reoccurence of those problems. In terms of being uprooted from the community, it means at least that the adolescent who returned three months—I use the figure three months as a rough average for how long adolescents spend in hospitals—the child will return in three months time to his or her neighborhood school and there will be very difficult problems in readjustment, the embarrassment of meeting peers who ask, "Hi, Joe, where were you?" What is Joe to answer—"Well, I was in the State Hospital."?

It is a difficult situation to impose on the child. There is at least temporary loss of the social support system that I spoke about earlier.

Now, in terms of the dangers and drawbacks of institutionalization per se, I feel on very firm grounds, because I think that the entire field of psychiatry has been sensitized to the dangers certainly of long term institutionalization. In a sense, the derailment from the usual course of one's life, the dreary regimen even in the most progressive hospitals, the extreme deprivation and limits, including simply going where one wants to, dressing as one wishes, corresponding or communicating with friends, relatives, et cetera.

These are extremes. Then, too, the term, (122) "stigma" has been mentioned several times. I'd like to spell that out in somewhat greater detail.

I think there is a social stigma and I think there is a self-stigmatization that occurs, too. From a social and legal point of view, it means that that person, every time he fills out an application for college, the military, driver's license, hack license, et cetera, employment, is obligated in most states or at least in many states to state, "I have been a mental patient," and that is certainly going to give the school or the potential employer cause. While attitudes have changed slightly for the better in terms of some greater acceptance of the phenomenon of mental illness, they have changed very, very slowly and I don't know that we can predict in 1974 how employer "A", "B", or "C" is going to react to the fact that someone who asks for employment has been in a mental hospital.

Lastly, the fact of being in a mental hospital has profound repercussions in terms of that person's self-image and self-confidence. No matter how much they might wish to dismiss it as even an unfair event—and maybe it was—or "I got into the hospital only because my Aunt Tilly couldn't stand me"—it shakes a person's self-confidence to the core and I speak from experience in dealing with many patients who have been (123) through hospitals.

When they have been designated a mental patient, because no matter how scientifically and how manly we look at that phenomenon, there are traces of much older superstitions about it and we really do distrust the judgment of those who have been labeled "mentally ill".

Q. Dr. Messinger, as a result of the analysis of institutionalization, do you have any opinion as to whether



or not there ought to be a prior hearing in the non-emergency situation of a juvenile for commitment to a mental hospital?

A. I think there definitely should and I think that there should be in every case.

Q. Can you explain, if you will, the reasons that you believe that children ought to have a hearing?

A. There are many.

One is to sort out the facts. One of the prior witnesses said that lawyers are better trained to ascertain matters of fact than psychiatrists. I think that is true. I think we emphasize different kinds of data, but certainly, there should be the most careful gathering and weighing and discrimination of the facts of the situation. That is especially pertinent, because feelings tend to run high in such matters. One does not (124) have such a serious breach in family integrity, in family unity, without feelings running high and what happens most often is that there is a decided difference of opinion between the parental generation and the child or adolescent, as to what is going on and what the implications of this are.

For example, when Mary, age 16, asks to go to the school dance Friday night, that might mean to her, "I wish to meet some new people. I want to have some fun. There is someone there who I'm looking forward to seeing."

To parents, from their perspective it might mean, "She is out of control. We have prohibited her from going out; she should do her homework instead. What is going to come of her if we allow her this next freedom?"

What I am saying is from each parent's point of view, there is a very different assessment of the facts.

Q. Could you experience situations where the family misperceived or misinterpreted facts, which, if true, would have meant involuntary treatment for the child, but if not true would have meant no treatment for the child?

A. It usually does not hinge on a single matter of (125) fact. I think it hinges on a consistency type of coloring of the facts and what one sees as relevant in another person's life and from that point of view, yes.

Q. Parents do select things out that might in a way color the facts that are presented to the psychiatrist.

A. That happens almost inevitably.

Q. Dr. Messinger, could you please describe, if you can, what benefits, almost in a therapeutic sense, a hearing might have for a child, a prior hearing?

A. I think the major one is that a child wants to be treated fairly and that a judicial hearing is just that kind of impartial way of the facts and objective decisions as to what is best done about them.

Q. What effect would that have on the treatment that might occur if the child was ordered to have treatment?

A. I would agree with I think it was—well, both the prior witnesses, that that frees up the treating psychiatrist whether in an institution or outside of it, to do the treatment, help the person sort out their feelings and thinking about their life experiences.

If I am in the dual position of incarcerating a youth and also of asking him, "How do you feel about being incarcerated," I am in an untenable position. That has been recognized in settings where administrative decisions are separated out from psychotherapeutic (126) responsibilities.



So one psychiatrist wears the hat of administrator and another as therapist and I can't imagine that there would be any harm in the facts as they are being laid out before the child.

In fact, I think that it would give him pause and might lead him or her to reassess their opinion.

Q. With regard to the possible delay prior to a hearing in an non-emergency situation, do you feel that that delay would mean in your opinion that there should not be a hearing or what do you mean would be the advantages or disadvantages in such a delay?

A. I don't see any disadvantages.

I think in fact that the situation is somewhat safer with children who will either be living at home and thereafter are under some scrutiny—

Q. Safer than with whom?

A. Safer than with adults.

This is the situation with adults in the state of Pennsylvania. If the danger considered is, what if the situation becomes deteriorated and becomes more dangerous?

I think we are on safer grounds with children, because they are under the scrutiny of the parents or if they are in a foster home, the foster parents and (127) usually the school, too. If the situation deteriorates badly, then there could be a reconsideration as to whether it has become an emergency situation, but I would underscore the statements of both the prior witnesses that there are major and dramatic shifts in the behavior of adolescents. If there is anything that characterizes the behavior of adolescents it is that they are changeable and that very bad situations can right themselves.

There is another factor here and that is, once a family comes to psychiatric or a social agency's attention, efforts can be made to help the parents better cope with the situation. That, in and of itself, might give the adolescent another opportunity to regain their psychological equilibrium.

Q. Dr. Messinger, I would like to ask for your opinion and comments on some of the facts that have been agreed to in this case with regard to one of the named plaintiffs in this lawsuit.

MR. FERLEGER: Just for the Court's reference and Mr. Roth's reference, paragraph 21 of the final prehearing order with regard to Leslie Levine. Levine's parents are divorced. Her father's remarried and living in family. She would have at the time of her commitment, at the time this action was filed, liked to have been with her father because she gets along well with him.

(128) Every time she visits with her father her behavior is excellent. Levine's difficulties in relating to her mother resulted in her commitment.

Hospital records indicate that Levine threatened the lives of her mother and sister and that she has "a personality disorder".

Q. I wonder if you can comment as to whether or not this is typical, that an adolescent's behavior might change so dramatically with the environment, here with the father she acts one way and with the mother she acts another way.

A. The answer is, yes, that that is typical. It is typical of adolescents and it is typical to some extent with all people, that who we are is a function of the social setting.



By the way, I think that that has relevance to the question of procedures to be undertaken before hospitalization, that if an adolescent is brought to a psychiatrist, let's say, in the admitting room of a hospital or even to a psychiatrist in a community clinic, such as my own, but knowing that the parents wish to commit that adolescent, that the social context will have much influence how the adolescent behaves.

For example, the adolescent might say to himself or herself, "I'm up against the wall. Mother (129) and Dad want to send me off to the State Hospital and here's the strange psychiatrist who I have never met—" and God knows what their fancies are about psychiatrists in general— "I better not open my mouth for fear it will make matters worse," or they simply will say, "This isn't fair and they are against me," and it sounds paranoid.

If that child was able to see someone who they knew was their advocate in a different setting, they might present a lot more information and a lot different sounding information than in, you know, the other settings.

To return to the example, though, I think that that example demonstrates that there are legitimate differences of opinion and interest within a family. Sometimes, as in that family, it is between two parents and the child happened to side with one, versus the other. One would have to ask why does she have the personality disturbance when living in Pennsylvania, but the disappearance in Florida. Oftentimes, though, the conflict of interests is between the parent generation and the adolescent, because they have very different attitudes, experiences and values. The question is not who is right, but the question is that this is a very real and sometimes extremely intense kind of conflict between the two generations.

(130) Unfortunately, and I think that this is very dangerous, the parents can sometimes utilize psychiatric authority to deal with the issue and the psychiatric authority can either say, "Yes, you are right, long hair and smoking marijuana is evidence of mental illness," and might go another step further and say, "This is a dangerous situation; the child ought to be in a psychiatric hospital."

We have to remember that in psychiatry, except for neurological diseases, we are dealing with behavior and the behavior that we are most concerned with is social behavior. That is how an individual influences or affects another.

Most often, the social system that we are concerned about is the family. It is—hospitalization is rarely done because of mental illness, per se. It is done because that person's behavior, whether you want to call it mental illness or not, in a way is beside the point, adversely affects, disrupts, angers, upsets, challenges, the interests and attitudes of the people that they impinge on.

Q. With regard to the regulations of the state as adopted, which involve an evaluation at a base service unit of one facility in Pennsylvania and then an evaluation at a state hospital, the facilities where the person is to be committed, do you see any difficulties with those (131) sorts of procedures?

A. Yes, I do.

Q. What are they?

A. For one, some of the concerns that I have had about, for example, the adolescent having the setting and whether the adolescent feels that this is the place where he can open up an share his true feelings as to what happened, I think that might be as true in a community facility as in a state hospital admitting room.



I know that from my own experience in a community clinic, it often takes months to really get to know a child, for them to open up and for me to gather data from the family, school and child that will give me a rounded and balanced view of the situation.

Q. So, you think that the evaluation that those regulations require might not really get the information needed to make a recommendation?

A. That's correct. The data we are dealing with is not hard scientific information.

You can't read a meter and the dial rests at one place or another. You need to gather information, sometimes the most personal, intimate and disturbing kind, about not only one individual, but a group of individuals, and not only about that one family, but their relationship to the community and school in which (132) they live. This is a painstaking and complete process. That was one of the reasons that I think a hearing would be in order. It slows down the momentum.

Q. Now, Dr. Messinger, do you see any difficulties with the state hospital confirming the recommendation of the referring psychiatrist?

A. I do, because psychiatrists are people, too, and we are influenced by considerations other than those that are strictly clinical.

For example, if I, as director of a state hospital get a letter from a colleague in a community facility, saying that John Doe really needs psychiatric hospitalization and is serverely disturbed, even if I felt otherwise from a direct discussion with the patient, I would be in an awkward position if I said, "No, this patient does not require hospitalization."

What do I then say to my colleague whose opinion I disagreed with?

Secondly, professionals—psychiatrists who work for institutions, are influenced by the needs of the institution, as well as the needs of the individual patient.

If I am the director of an adolescent service and the funding of my unit depends on how fully utilized the unit is, I might be on the side of admitting (133) the adolescent. I am not saying this is done deliberately, but I think that a decision as complex as hospitalization is influenced by factors within the psychiatrists at a number of different levels and such considerations as bed utilization will play some role.

Thirdly—

Q. Doctor—

A. There is another consideration.

Most of the data that we use in making a clinical assessment of a child, comes from the parents. We usually do not depend all that much on the child or adolescent giving us a full, detailed view of their life, so that the information that largely influences the first psychiatrist's decision will be the information that largely influences the second psychiatrist's decision.

From that point of view, I think it is—necessary to bring in—it is preferable to bring in someone from a different discipline, namely a lawyer, and working in a very different kind of setting.

Q. Now, Dr. Messinger, do you see any reason why there shouldn't be a hearing for younger children who might not object in their commitment?



A. I think in fact that the need for a hearing in the younger children is greater, because one cannot expect them to understand fully, certainly in legal terms, their (134) dilemma, nor can they be aware of alternate forms of therapy.

Now, obviously, the form of such a hearing and how the child is to participate in it will be a matter for, I think, very delicate—very delicate concern. I think that most any child can have some meaningful input into a discussion of his or her future.

The input from a five year old will be very different from a nine, thirteen and eighteen year old. One cannot ask—one has to speak the language of the child and listen to the language of the child, but I think that because younger children are less sophisticated and less knowledgeable, that we have to bend over backwards to protect their rights.

Q. Now, Dr. Messinger, do you see any difficulties with the state's provision of a hearing after commitment, especially for a child who might after a hearing, be found not to have been in need of commitment in the first place?

A. I think it is a most inadequate provision and it is closing the barn door after the horse is out. I think it is disastrous to hospitalize a child and then find out, by golly, it wasn't necessary. That is playing with a child's life.

Q. Dr. Messinger, the regulations also provide that (135) once the child between 13 and 18 is placed in an institution, that the child may then raise an objection after being read a notice that he or she may do so. Do you have any opinion with regard to the validity or the possibility of objections being raised at that point?

A. I don't understand the question.

Q. Once the child gets read the notice of his or her rights, that they may object and then obtain a hearing, do you see any difficulty with the validity of the possibility of the child raising that objection once the child has already been in the institution?

A. Possibly—let me think this out.

One is that the child is then in some wise at the mercy of his keepers and might tend to simply accede to their point of view.

Secondly, there is a kind of indoctrination and I am not using the word in that sense exactly, but there is a kind of indoctrination that occurs whenever a person is in an institution. The kind of indoctrination that we psychiatrists do is to say to somebody in a mental hospital, "You are ill. You have personality difficulties within you. You need treatment." And almost universally it is said, "The treatment that you need is the treatment that we are providing."

So, this I think also would make it more (136) difficult for the adolescent to say, "No, wait, I see things entirely differently."

Q. Dr. Messinger, just to finish up a few miscellaneous points, is it your opinion that adolescents can or cannot apply for admission to facilities on their own or ought they to have the parents' consent or advocation?

A. That is a delicate question.

I would like to see adolescents be able to obtain psychiatric treatment as out-patients and even as in-patients, because they felt it was necessary, if indeed the psychiatrist agreed—



Q. Of course.

A. —because there are instances that the adolescent is troubled and knows it and the parents have a need to deny it.

I am not in favor of doing this behind the parents' back. You know, I am a parent myself and I want to know what is happening with my children. I know that there is a trend towards giving adolescents greater discretion about seeking medical treatment on their own and I would hope that that would be extended to psychiatry.

In fact, that is done; it is done.

Q. Dr. Messinger, what is your opinion with regard to whether or not the involvement of a lawyer as Counsel for a child would interfere with the ability of the child (137) psychiatrist such as yourself to deliver needed services to juveniles?

A. Could you be more specific as to how it would interfere, because offhand, I don't see how.

Q. I am asking you whether or not you feel it would interfere?

A. I see no reason to think so.

MR. FERLEGER: No further questions at this time.

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*Cross-Examination*

BY MR. ROTH:

Q. Dr. Messinger, I will just ask you a few questions.

Are you opposed to institutionalization?

A. I think that hospitalization or institutionalization for example, in a facility for mental defectives, should be

a last resort and that as much work as possible, as much effort as possible should go into finding some other resolution of the child's and family's difficulties.

I have recommended hospitalization for children and adolescents when I thought that all other remedies had been used.

Q. Then, is it my understanding that you feel that institutional treatment is a good treatment program, if the institution is rendering good treatment and the child needs institutional treatment; you have no problem (138) with that concept, then?

A. Correct.

Q. Didn't you, in fact, write an article, "A Psychiatrist's Views of Institutional Treatment of Young Adult Offenders," in 1965?

A. I wrote the article.

Q. Doctor, you have testified about stigma. Let me ask you, to avoid stigma, would you not hospitalize one in need of such?

A. It is like so many of these questions, a matter of judgment and in weighing whether someone should be in the hospital or not, I would consider, and particularly for a younger person, what effect will this have on his later life, because a move done at a certain point in that person's life, while it seems judicious then, might later turn out to have harmed him and there are examples of a person who entered the hospital sometimes on their own for a two month period and then wanted to go to medical school five years later and was denied admission.

I guess one can argue one way or the other as to whether that initial psychiatric hospitalization was in the overall long term best interests of that person or not. I



am just saying that we have to be cognizant of the enormous social toll that institutionalization brings.

(139) Q. Fine, I appreciate that answer.

The question still remains, Doctor, to avoid stigma, would you not hospitalize one who is in need of hospitalizaion, who requires that and that's the only form of treatment that can be given, because other treatments have been explored, but they are not acceptable for treating the person at that particular level?

MR. FERLEGER: Objection. He has just answered that question.

JUDGE GIBBONS: No, he did not.

Overruled.

A. If the person requires to be in the hospital, then, they require to be in the hospital and I would assist in that.

Q. But the question remains, to avoid stigma—

JUDGE GIBBONS: He has answered that question now. Pass on to something else.

Q. With regard to patient Leslie Levine, whom you addressed yourself to, are you aware of the personality disorder of Leslie Levine?

A. I know no more about Leslie Levine than what the Counsel read.

Q. Now, you have testified that institutional psychiatrists do not become involved with family orientation.

Is that true in Pennsylvania? Are you (140) aware of that in Pennsyvania?

A. As a rule, and I have not spoken to psychiatrists who work in Pennsylvania state hospitals, as a rule, psy-

chiatrists who choose to work in institutions do not have a strong commitment to a family outlook on psychiatric problems.

Q. Do you have any statistics to buttress that statement, any articles?

A. In a negative sense, yes.

I know that those who worked in such institutions do not write articles about the family aspects of psychiatric problems.

MR. ROTH: Your Honors, I have no further questions.

JUDGE GIBBONS: Dr. Messinger, you spoke about the possible therapeutic benefits of a hearing, precommitment hearings for the child, because the child wants to be treated fairly.

Is there any empirical data as to how children perceive the judicial process?

THE WITNESS: I don't know any.

JUDGE GIBBONS: In the absence of such data, how is it possible to say that the child will receive a therapeutic benefit from a perception of being treated (141) fairly, if in fact, the data suggests that children perceive the judicial process as hostile and unfair.

Would your conclusion of a therapeutic benefit still follow?

THE WITNESS: I am not happy with the term "therapeutic benefit". I believe it should be done, because it should be done, to protect the interests of



THE WITNESS: I would assume so.

JUDGE GIBBONS: Why do you assume so?

THE WITNESS: I might be in error, but I would assume that the authority of the Court might be such that they might, for example, obtain information about the family, that the family would not voluntarily impart.

For example, if parents have committed another child or have been accused or tried for child neglect or have criminal records or the like.

I might be wrong about this, but I assumed that the Court would have authority to obtain such information while the psychiatrists, we are only able to hear what the person wishes to say.

JUDGE BRODERICK: Doctor, I just wanted to clarify one thing.

Other than what we have been referring to (143) as the "emergency situation," are there any cases where you recognize, in connection with the treatment of juveniles, that the in-patient care is preferable to the out-patient care?

THE WITNESS: Yes.

JUDGE BRODERICK: What would one of those be, for instance?

THE WITNESS: It came up recently with a 14 year old boy who I had been seeing on and off in the clinic for the last four months or so.

It so happens that his hospitalization occurred during a time when I was on vacation and the police

the child. I believe that if it is explained properly to the child, they could understand that the judge is a person who will try to find out what is the matter and what is best to be done and that that judge is not—is a different kind of adult than a parent.

JUDGE GIBBONS: Is the process of explaining, with respect to the judge's role, any different than the process of explanation with respect to the psychiatrist's role?

THE WITNESS: I am not sure if—

JUDGE GIBBONS: You spoke of the duality of the role of the psychiatrist.

THE WITNESS: Yes.

JUDGE GIBBONS: Wouldn't the same explanation serve that purpose? That is, serve the purpose of removing from the child's perception the thought that the psychiatrist was somehow his enemy or persecutor?

THE WITNESS: Indeed, I think it is a fact (142) that a psychiatrist who works for an institution does have a dual allegiance and I don't think that the judge who sits on such a case does.

JUDGE GIBBONS: You testified that most of the data that the psychiatrists rely upon under the Pennsylvania dual interview system comes from the parent.

Is it your perception that in a judicial proceeding the Courts would be more able to get information from other sources than the psychiatrists?



had to be called. However, I was considering hospitalization for him and had shared that fact with both him and the parent.

Without going into the details, I think the considerations here were the severity of the pathology, the possible danger of the pathology, how chronic it was and most importantly, how poorly motivated the boy was to obtain treatment.

So, when I and others at the clinic offered him a variety of approaches, medication, sessions, counseling sessions, a summer program, a change in school, he turned his back to all and I had to tell him, "You are forcing the issue and you will have to be hospitalized (144) if you don't make yourself more receptive to things that we might try on an out-patient basis."

As I said, it so happened that he, in a sense, decided that matter in my absence, but I would have hospitalized him.

JUDGE BRODERICK: In his particular case, do you see where there may have been an advantage to have a court hearing to determine his commitment?

THE WITNESS: I think the advantage would have been then, not only I as his psychiatrist, but a separate adult in weighing the evidence came to the same decision and if the judge did not, then I would have to ask myself, you know, in what way did I error and how can I re-examine and revamp my treatment planned, so that it is more effective for this child.

JUDGE BRODERICK: What would you perceive in your view of a judicial hearing for that

young man; what would you imagine would have taken place?

JUDGE HUYETT: Could I add something to that?

What would be the issues of such a judicial hearing? What issues should be decided?

THE WITNESS: I think first of all, an agreement on what are the facts.

Secondly, some assessment of how severe (145) the pathology or disturbance of the child is.

Thirdly, how dangerous the situation is, or might become.

Fourthly, what else has been tried and what else might be tried.

Fifth, what the adolescent himself says about the matter and what he thinks might be best for him, and, sixth, what the family thinks would be best for the boy.

JUDGE BRODERICK: But in that situation, as you would apparently envision that you would testify as to what your opinion is?

THE WITNESS: Yes, I think I would testify as to the facts as I knew them, my experience in working with the boy, something about diagnosis and making a recommendation.

I think the advantage there would be that if the child were then hospitalized, when he came out of the hospital and returned to our clinic, which I think is the only psychiatric facility available in that neighborhood, I would then resume the treatment without my having been in the role of his—the guy who sent him away.



JUDGE BRODERICK: In that situation and I am still talking about the same young man being (146) represented by an attorney at a hearing, would it not be incumbent upon his attorney to perhaps try to find a psychiatrist who would take the position of the child, if he didn't think he should be committed?

A. Yes, I would hope that that would happen, because we are not dealing with black and white matters. We are dealing with very complex—with people who are complex and situations—human situations are very complex and I would want, if there was another professional who took an opposing viewpoint, I would want that viewpoint presented.

JUDGE BRODERICK: Thank you.

MR. FERLEGER: No further question, your Honor.

MR. ROTH: None, your Honor.

(Witness leaves the stand.)

JUDGE GIBBONS: Do you have any further witnesses?

MR. FERLEGER: No further testimony.

With regard to the plaintiffs' Exhibits, I would like to move for the admission of Exhibit No. 1, which are the affidavits of the two juveniles, regarding which Mr. Roth, this morning, was granted ad-

mission of his counter affidavits and I don't believe there is any objection to that.

(147) MR. ROTH: No objection.

JUDGE GIBBONS: Will Counsel take care of marking it afterwards and we will get on with the testimony afterwards.

(Whereupon two affidavits of juveniles were marked plaintiffs' Exhibit No. 1.)

JUDGE GIBBONS: I take it you are offering Dr. Messinger's Curriculum Vitae?

MR. FERLEGER: Yes.

(Whereupon, the Curriculum Vitae of Dr. Messinger was marked plaintiffs' Exhibit 5 in evidence.)

MR. FERLEGER: With regard to two and three, Judge Huyett said we would be able to present them to you—

JUDGE GIBBONS: Does it make any difference whether we rule now?

MR. FERLEGER: No difference. I would be willing to renew this motion at the end of the testimony.

JUDGE GIBBONS: You have made your offer and we will consider that.

MR. FERLEGER: Thank you, your Honor.

JUDGE GIBBONS: Do you have a witness?

MR. FERLEGER: Yes, your Honor, we do.



LEVON DONALD TASHJIAN, sworn.

THE CLERK: Would you state your full name?

THE WITNESS: Levon Donald Tashjian.

(148) *Direct Examination*

BY MR. ROTH:

Q. What is your profession?

A. Medical doctor and psychiatrist.

Q. Are you licensed to practice medicine and psychiatry in the Commonwealth of Pennsylvania?

A. Yes, I am.

Q. Where did you obtain your license, please?

A. I went to medical school at the University of Pennsylvania, interned at Pennsylvania Hospital and obtained my Boards.

Q. Where are you presently employed?

A. Institute of the Pennsylvania Hospital.

Q. Doctor, where did you perform your residency?

A. Jefferson Medical College Hospital and Hospital of the University of Pennsylvania.

Q. What specialities do you pursue?

A. I am Board certified in psychiatry and my specialty is adolescent psychiatry.

Q. How long have you been practicing?

A. For over eight years. That is, eight years following colleges of residency.

Q. What has your role been at the Institute?

A. From 1968 until July of this year, I was associate director of the adolescent treatment center at the (149) Institute, and since July, I have been director of the young adult program and unit at the same hospital.

Q. Are you the recipient of any awards?

A. Yes, I am. I think listed there is the Sol Ginsburg Fellow, for the Group for the Advancement of Psychiatry.

MR. ROTH: Do you have any cross-examination?

MR. FERLEGER: No.

MR. ROTH: Your Honors, at this point, may I introduce to the Court the Curriculum Vitae?

JUDGE GIBBONS: Yes, what is your next number?

MR. ROTH: I am not sure which Exhibit number it is.

JUDGE GIBBONS: You will take care of giving it a number and let us know.

MR. ROTH: Thank you.

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*Continued Direct Examination*

BY MR. ROTH:

Q. Doctor, have you participated in the admission of juveniles at your institute?

A. Yes, I have.

Q. Would you please explain how a juvenile is admitted at your institute?

A. Fine, let me explain—first of all, give a general overview and then give a view of my procedure of evaluation of a juvenile.

(150) In general, the Institute, which is a private psychiatric facility, receives patients upon referral either



Now, in case of pressure of time, this process may be established—may take place during one day and even in the most serious and complex instances, it might require a couple of hours to make this evaluation. Where there is more of a luxury of time, we may stretch out this evaluation over a several day period.

Only when I have made such an evaluation, will I recommend or not recommend hospitalization.

Q. Doctor, what percentage of those juveniles whom you see, do you advise institutionalization for?

A. I think 60 to 70 percent. Roughly 30 to 40 percent of those who are brought to me or come to me for evaluation, it is my recommendation that other forms of treatment or (152) occasionally no treatment should be the choice.

Q. And, have you had situations where the parent insists on institutionalization?

A. Yes, I have, in the face of my not recommending institutionalization. Is that correct?

Q. That's correct or in the alternative where they indicate at the outset they want to put their child into your institution.

A. Yes.

Q. And, what do you do then?

A. If I do not feel that the young person demands or needs hospitalization, I certainly will not admit that young person even if the parents are absolute in their demands.

Q. Just traveling along this path where the parent comes with his child, do you find that the child generally objects to being admitted when you are recommending admission?

from a base service unit, other institutions or from private referrals in the area.

They may come from within the Philadelphia area or they may come from as far away as the West Coast.

So most young people who come to the Institute, come having been seen prior to arriving at the hospital.

Before anyone can be admitted to the Institute, they have to be seen and evaluated by one of our attending staff at the hospital and then he either concurs or disagrees on the question of admission for that young person and at the time of admission, the young person and his family are seen again by at least the resident psychiatrist prior to admission and then, in the days following admission, and I am talking about 24 to 48 hours, he is seen at least by one and often more likely a half dozen other psychiatrists who are members of the staff of the Institute.

Now, my procedure and I think it is important to mention this, in evaluating a young person, is as follows:

Parents will often initiate the request for evaluation and they will often come to me requesting (151) or stating that their child is mentally ill and requesting hospitalization, but simply because a parent requests hospitalization is no reason that of necessity we will go along with hospitalization as a part of my evaluation, my standard procedure is to first of all see the child with his parents and preferably with any other siblings, if they are available or can be brought in for that evaluation and then next, I would like to see the child individually, alone, and then I would like to see the parents alone, and finally, in this four-step procedure, I would like to see the entire family together, prior to my deciding on the question of admission to the hospital.



A. We are talking now about young people who are evaluated and are deemed in need of hospitalization?

Q. Yes.

A. I think our adolescent unit admits between 60 to 75 patients per year and since its inception in 1966, it has done this, and depending upon whom you talk to, between 90 and 99 percent of those adolescents admitted to the (153) hospital object and at the time of admission, to admission. So, we see that the percentage of those who object is very, very high.

Now, one must evaluate carefully the nature and the quality of that objection, and one must see, if I can make some generalizations about the common aspects of those objections.

First of all, a young person is liable to be frightened, absolutely frightened by the thought of his having a mental illness and by the thought of his having to go into a hospital, a mental hospital, and we all know what stereotypes there are that abound about mental hospitals, asylums, looney bins, et cetera.

Secondly, young people, adolescents, are in the stage of development where they are in the process of separating and individualizing themselves away from their parents, away from their family of origin, and any number of writers in the field, experts in the field, have commented on the fact that essentially in this process of separation, et cetera, the young person uses the defense mechanisms of projection and externalizations, that is, commonly, he blames his faults upon the world, whether they be the world of his parents or the world of his family, the world of his school or the world at large and so, commonly, you will hear the young person (154) say that it is not he who

should be here, but it is his parents or it is—commonly, the parents and occasionally a sibling. These are two general themes that commonly underly the objections that a young person brings with him.

Q. Doctor, are you familiar with the juveniles who have been admitted to the Institute of Philadelphia in the past two to three years?

A. Yes, I am.

Q. Are all the admissions of these juveniles reviewed with you?

A. Most of them, certainly, yes.

Q. Doctor, have I advised you that the Department of Public Welfare sent a questionnaire regarding admissions of juveniles to mental health, mental retardation facilities, last year?

A. Yes.

Q. Have I advised you that one of the questions asked was: "What was the reason for the juvenile's admission or commitment or precipitating behavior warranting admission or commitment?"

A. Yes.

Q. Have I indicated that we received, briefly, responses from your Institute?

A. Yes.

(155) Q. Have I asked you to review the admissions of these juveniles?

A. Yes, you have.

Q. I would like to refer to the prehearing order and in particular to page 15, where it was indicated, "Children have wound up at institutions for the following reasons in addition to their being mentally retarded" and with reference specifically to the Institute of Philadelphia Hospital, Dr. Tashjian, could you please indicate the nature



of the admission of 949433, where the reason given by the Institute is family conflicts?

MR. FERLEGER: Objections, your Honor, unless he has with him the patient's records which can be examined with a court order for confidentiality.

I don't see how unless he testifies that he has been personally involved with that patient and has some foundation that he can testify to that.

There is no way I can lay any groundwork for cross-examination about a particular patient.

JUDGE GIBBONS: What is the purpose of the offer?

MR. ROTH: Your Honor, I wanted to show that I believe there's been an implication made by plaintiffs that, based on the description of the precipitating behaviors that was the sole reason and there is (156) nothing beyond that and I wanted Dr. Tashjian, who has already testified that he has reviewed the juveniles that he was the associate director for of the adolescent unit whereby these juveniles came through his review, and I wanted him to testify with regard to any conditions that may have warranted an admission.

MR. FERLEGER: If I may respond, that point of view was raised in Judge Huylett's chambers and Judge Huylett ordered that Mr. Roth supply a sample of 10 fuller records which he has already supplied and which we don't object to, so whether or not the statement reflects, the reality is so.

MR. ROTH: I am not trying to bring in record of other patients. I am not trying to say one was exclusive of the other.

When we were before Judge Huylett, as I recall, plaintiff and I had agreed that we could select the profiles of 10 patients with regard to pre-admission notes. At that same time, I don't think I excluded the possibility of have any expert witness testify as to the reasons of the admission of any juvenile.

JUDGE HUYLETT: Would you gentlemen indulge us for just a moment, please?

JUDGE GIBBONS: I don't think we need detailed testimony on this particular case. The prehearing (157) order provided for the production of the 10 samples and I think for the purposes of this lawsuit, that is sufficient.

MR. ROTH: All right.

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*Continued Direct Examination*

BY MR. ROTH:

Q. Doctor, let me ask you this with regard to admission of patients in your Institute.

For example, if a patient comes in and one of the problems seems to be weight loss, what other reasons could be indicative of the admission of that patient?

A. Let me first respond in a general way that the reason for admission, and this is something every medical student is taught, during his first and second year of medical school in history-taking is, a composite of the patient's chief complaint which one must take down verbatim, so if you ask the patient, "What brings you here?" and the patient responds, "The trolley.", the doctor would put down the concrete inappropriate response of "The trolley" for chief complaint, and then the physician would sometimes use a few words to describe reason for admission.



Now, it may be because of—let me use a general medical example first before I get to the psychiatric example. It may be for bellyache or abdominal pain. So we have that as the reason for admission—abdominal pain let us say. That can vary all the way (158) from abdominal pain secondary to a hangover from the night before or from having eaten hot peppers to an inflamed ulcerous state and it runs a wide gambit, so to respond to your question specifically about weight loss, that in and of itself that as a reason of admission is drivel unless clarified and amplified.

There are serious—extremely serious, life threatening psychiatric conditions which have as their presenting complaint weight loss.

Q. Would that necessarily hold true for children who come to you that are labeled "runaways," or in conflict with their parents or anything of that nature?

A. Absolutely.

Practically every family with teenage kids knows what it is to experience conflict and in and of itself, family conflict is universal. One has to evaluate the quality of that conflict, the degree of that conflict, the lack of resolution—potential resolution of that conflict and to go back to my evaluation as I said, of an adolescent, that would include

evaluation of family members. It would include looking to what the parents bring to the situation that impinges upon the young person who is designated as the patient or patient-to-be and at times it may be tremendous.

Q. How do you distinguish non-emergency from emergency?

(159) A. I think the Mental Health and Mental Retardation Act of 1966, states that if a person is suicidal or homocidal, that qualifies as an emergency condition.

So, in argument from that standpoint, everything else falls into a relative non-emergency situation, but within non-emergency situations there are those situations where one has the luxury of time on the one hand and on the other hand, there are those situations where one really does not have the luxury of time—where something must be done posthaste—lest the situation escalate or inflame into a potential emergency situation.

Q. In your opinion, Doctor, do you see any advantage of having a parent admit his child to the Institute or in the alternative, having to undergo a judicial proceeding, whereby the parent and juvenile are acting in adversary roles of one another?

A. Again, I want to clarify, and this may seem like nit-picking, but the parent, maybe in a legal sense, does admit the child, but in a psychiatric medical sense, does not admit the child.

The child does not come in because the parent wants the child to come in. The child only comes in after two individual evaluations, at least, and oftentimes in the young people that we are dealing with, they have had several evaluations. They have also had trials (160) of treatment



elsewhere before they are brought to the Institute, before that is considered. I think this;

I will go back to what I said earlier, that 90 to 99 percent of the young people who are admitted to the adolescent treatment center protest in some form or another.

Now, I am sure that if we were to offer—if we were to offer the possibility of having an adversary type hearing, if that was available prior to hospitalization, that a good percentage of those might elect such a hearing, but what happens, once the young person is in the hospital and immediately upon hospitalization, he is informed of his rights in a humane manner by members of the staff and according to Title 55, we carry that out to the letter, that once a young person is hospitalized, of the 90 to 99 percent who objected prior, the overwhelming majority have accepted hospitalization and give up their protests, even though the free legal counsel is available to them just for a phone call, and a free phone call at that.

Now, why does this happen? It happens for a number of reasons. One of them being that most young people are ambivalent in terms of their needs to be hospitalized. Most young people, where the admission is appropriate for psychiatric reasons—again, if I can digress (161) for just a second—no, I will come back to that later, excuse me.

There is an ambivalence and once, in a sense, put into a situation, then a large part of the struggle is over. Once a young person also gets into a situation and finds it is not such a fearful situation, that he is going to be treated humanely, and once the young person has the opportunity to talk with other young people, his peer group,

who are hospitalized there themselves, that these are some of the factors that we think significantly cut down the degree of objections that take place among hospitalized adolescents within the first 24 hours of hospitalization.

Q. Do you feel that juveniles should be able to admit themselves?

A. No, I do not.

Q. Why do you feel that they should not be able to admit themselves?

A. I am aware of Senate Bill 1239, Senator Coppersmith's bill. I have participated in helping to shape that bill and I am aware in that bill in dealing with minors, there is the question of whether 14 year olds should be looked upon as if they had reached their majority, and again, from a psychiatric standpoint a 14 and 15 and 16 year old has not really reached his majority; that in the process (162) of his development, in the process of his separating himself off from the family of taking an individual autonomous stance with himself, some of the things we lump together under the general rhetoric in the process of his developing his personal sense of identity, the young person is in conflict commonly with his parents and I would point out to you that how many of us sitting in this courtroom were not at some point and at time maybe in a major way in conflict with our own parents in the process of growing up and how we now look back upon that conflict.

I don't feel that minors have the judgment to decide for themselves when they want to see a psychiatrist and when they don't want to see a psychiatrist. I feel that they can aid and collaborate in that judgment. I feel that they have a voice and that voice must be heard. I feel it is an essential voice, but I do not feel that a young person in



and of himself, by himself, can make a decision of that magnitude.

Q. If a juvenile presents himself or herself at your Institute and seeks help, what would you do?

A. Okay, what would I personally do?

There are some of my colleagues who might do differently. If that young person saw me—requested to see me, I would see him. For the purpose of ascertaining his complaint. If I felt his condition required (163) emergency measures, then I would attempt to contact his parents and any other authorities necessary to protect him. Whether that young person wanted me to contact his parents or not. I, personally, would not undertake to treat that young person unless he allowed me to make contact with his parents and to see his parents and have commonly, my experience to include his parents in the treatment. If we are going to talk about family systems, as the previous witness has, in terms of seeing the family system as the nucleus, then, it is important that we not allow any one member of that nucleus to fail, whether it be the young person or the parents.

Q. Have you taken part in the hearing for institutionalizing of juveniles?

A. Yes.

Q. Do you feel that hearing is traumatizing on the juvenile?

A. Yes. It damages what is usually a weakened family situation. It pushes that family to the wall even further. Oftentimes, when a young person is in distress and his family is in distress, there is a lot of acrimony, a lot of verbal violence, occasionally some physical violence and a lot of hate and in my experience, going to a Court and having an adversary situation escalates that.

The second point I'd like to make is what (164) is the Court to ascertain? It's been mentioned here that the Court is to ascertain the facts. Again, I am not comparing us with lawyers, but physicians from the early days in medical school are taught in history-taking and I did this both as a student and teacher when I was teaching medical students at the University of Pennsylvania, are taught to assess the reliability and validity of information gotten from the patient and other informants who talk about the patient.

When I talk with the parent and the parent tells me that Linda Sue wants to go to the dance, rather than stay home and study, I feel a competency to evaluate the truth of this and by the way, I am going to get Linda Sue in and have her respond to this and I am going to look at the equality of the complaint and sometimes I am going to hear some very absurd complaints.

I, as a physician and psychiatrist, am in a position to evaluate this. If the other point is in addition to facts, we are here to evaluate the mental status of the individual, something that is more intangible, something to be sure does involve judgments and is subject to error, but we are here to evaluate the motivation, the mental status and the whole emotional make-up that lies behind the behavior that the young person presents and the complaints that the family expresses and may have.

(165) So, again, we may have a young person whose reason for admission is that she is hospitalized because of family conflict and we would say, "My goodness. How unfair it is to do this." We have to go deeper; what is the nature of that family conflict? How is that individual, the so-called designated patient, affected by that family



conflict? How profound is her disturbance? How is it likely to continue if she remains within the confines of that family? Is there a possibility that one as an outpatient can get a hold of this family in treatment or the parents in treatment or does one make a treatment that one can't get a hold of soon enough and if one lets one go, might she not suffer great harm?

To use an analogy, someone is made very sick by, let's say, the escape of chlorine gas as occasionally happens here in Philadelphia and other places. Now, to deny that person hospitalization, because the reason for admission is chlorine gas, when you really want to get and bottle up the cannisters of the train cars of chlorine is absurd. One has the responsibility to protect and to treat the individual once one makes a decision that that individual is suffering from severe emotional disturbance whatever the causes are.

Q. Doctor, your Institute, I would assume, is fairly expensive per day; is it not?

(166) A. Yes.

JUDGE HUYETT: What are the daily charges, roughly?

THE WITNESS: Roughly in the area of $110.00, $120.00, $125.00 a day. I must say it is not—well, that sounds defensive. I'll let it stay.

Q. Have you ever found yourself in a situation where a patient required in-patient care at your Institute, however, the family finances or insurance coverage was not able to meet all these costs and you had to recommend another institute or an institution?

A. Yes, I have.

Q. Have you ever recommended a state institution?

A. Yes, I have.

Q. And, what state institutions have you recommended?

A. Norristown and Haverford State Hospitals.

Q. Do you find that out of those institutions, when you refer a patient, that the patient is then evaluated by the staff at either one of those hospitals?

A. Yes.

Q. Do you find that at those hospitals, the psychiatrists are not only looking to the prospective or designated patient, but also they look to the family?

A. Yes, that's been my experience.

Q. What I am trying to get at, Doctor, as a private
(167) psychiatrist at a private facility, as you may have heard before, there was some claim that psychiatrists at institutions do not involve themselves with the family and look strictly or focus strictly on the designated patient; is that your experience?

A. I think what we are talking about as a new trend in adolescent and child and general psychiatry, of looking at the family system, which is a derivative of the so-called "general systems" theory and it's been my experience that this is common knowledge now to anyone in psychiatry who has been doing any reading at all in the last 10 years.

Q. Doctor, do you have any idea how many juveniles have objected since September of 1973, roughly in your institution?

A. Objected—

Q. To their admission—

A. To the point of contacting—

Q. A lawyer, yes.



A. Of let's say roughly 75 patients in that time, maybe a dozen have objected to the point of contacting a lawyer, and I think two or three objected to the point of going for a Court hearing.

MR. ROTH: I have no further questions, your Honor.

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(168) *Cross-Examination*

BY MR. FERLEGER:

Q. Dr. Tashjian, you mentioned charges of $120.-00—

JUDGE GIBBONS: Do you expect your cross-examination to be prolonged?

MR. FERLEGER: Probably at least 20 to 30 minutes, your Honor.

JUDGE GIBBONS: As I told you earlier, that won't be possible and since the Doctor would have to then return in any event, perhaps we should recess now.

MR. FERLEGER: Certainly, your Honor.

JUDGE GIBBONS: We will resume Wednesday morning at 9:30 A.M.

MR. ROTH: Dr. Tashjian will commence at 9:30 Wednesday, be the first witness and he will continue his cross-examination?

JUDGE GIBBONS: Usually, when I grant a recess before cross-examination, it prolongs the cross-examination. Think about that carefully.

MR. FERLEGER: Thank you, your Honor.

JUDGE BRODERICK: You mean you want him to be different or not to be?

JUDGE GIBBONS: It is usually not useful.

MR. FERLEGER: I will just note that I have given the Clerk, you might want to take with you, copies (169) of the deposition of Dr. Barbara Armstrong.

JUDGE GIBBONS: Would you take care of, today, of getting the Exhibits marked?

MR. ROTH: Yes.

(Whereupon, at 3:55 P.M., Court was adjourned until 9:30 A.M., Wednesday, September 11, 1974.)



EVIDENTIARY HEARING
SECOND DAY

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Philadelphia, Pa., September 11, 1974
(9:30 a.m.)

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Before:

Hon. John J. Gibbons, C. J.

Hon. Daniel H. Huyett, 3rd, J.

Hon. Raymond J. Broderick, J.

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(172) (All Counsel and parties being present, the following transpired in open Court.)

JUDGE HUYETT: Good morning, gentlemen.

JUDGE GIBBONS: Good morning.

JUDGE BRODERICK: Good morning.

MR. FERLEGER: Good morning, your Honors.

MR. ROTH: Good morning, your Honors.

JUDGE GIBBONS: Mr. Roth, are you ready to proceed?

Mr. ROTH: Yes, your Honor.

On Monday afternoon, we had completed our direct examination, as I recall. We have no further questions.

JUDGE GIBBONS: Dr. Tashjian, would you resume the stand?

(LEVON D. TASHJIAN, previously sworn, resumed the stand and testified further as follows:)

*Cross-Examination*

BY MR. FERLEGER:

Q. Dr. Tashjian, how many psychiatrists do you have on your adolescent unit at the Institute of Pennsylvania Hospital?

A. There are two sets of answers for that.

In terms of administrative responsibilities for running the unit, there are four Board qualified or Board certified psychiatrists. At least two and usually four residents in the second year of psychiatric training and there are a number of attending psychiatrists who are on the staff of the Institute who admit—

Q. How many are they?

A. Well, there are approximately 160 psychiatrists associated with the Institute.

Not all of these psychiatrists by any means work with or treat adolescents, and I would say maybe we draw from a pool of 30 or 40 attending psychiatrists.

Q. How many other treatment staff are there, approximately?

A. In the—

Q. In the adolescent unit.

A. We have a very large treatment staff. We have a certified and accredited school with a faculty of 12 to 15. We have multi-disciplinary recreational and therapy departments with a staff of four to five, plus a good complement of nurses.

Q. Your program there is a rather unique program in the city, isn't it?

A. We think so.



Q. And, I would guess from what I have heard, since we sought you as a witness for our side, that your program is rather unique in the country; would you agree?

(174) A. No, I think that there are—we think it is a darn good program and we will match it with programs—

Q. Is the program in most of our state hospitals for adolescents?

A. I think so; yes.

Q. You mentioned that you refer people who can't afford the $120.00 a day fee to Norristown State Hospital or Haverford State Hospital; is that right?

A. Yes.

Q. Do you refer people to Philadelphia State Hospital?

A. I have not had occasion to.

Q. Why not?

A. Because people—well, my patients—primarily, because those patients with whom I would refer have not fallen into that catchment area.

Q. Isn't it another reason that Philadelphia State Hospital does not have an adolescent program; it isn't such a good hospital to begin with?

A. I have no direct familiarity with Philadelphia State Hosiptal.

Q. What is its reputation?

A. It's reputation is pretty much as you describe it.

Q. Dr. Tashjian, I am asking these questions, because you testified about your procedure and you emphasized the word, "your" for admitting adolescents. You don't (175) have any knowledge of the procedures at Philadelphia State Hospital or other state hospitals around the

state, except for Haverford and Norristown; isn't that right?

A. In general, yes.

Q. Yes, you do not have knowledge?

A. Yes, that's true.

Q. So, that when you testified that you do a full-day evaluation, you do not know if the state hospitals or state facilities for the retarded which typically have fewer staff, you don't know if they are as extensive as you are personally in your evaluations; isn't that right?

A. No, I must say, if I can state this, that I do a fair amount of teaching and in the places that I do teach, I do recommend my form of evaluation as a standard form of evaluation.

Q. I understand that. I hope your students follow your recommendation.

Now, Dr. Tashjian, with regard to the replies that your Institute made to the defendants' interrogatories which will be part of the record in this case, you testified that you were familiar with those replies; is that right?

A. Yes.

Q. And, you are aware, are you not, that those replies indicate that in 1972, there were no Section 406 Court (176) commitments to the Institute; is that right?

MR. ROTH: Objection, your Honor.

Dr. Tashjian testified with regard to the particular patient profiles that I had alerted him to. He has not said on direct examination that he was aware of all the responses to that questionnaire.

MR. FERLEGER: Mr. Roth, can we stipulate that this is the response and no Court commitments were reported by the Institute of Pennsylvania Hospital in 1972?



To save time, let me withdraw that question.

Q. Isn't it correct, Doctor, that the Institute generally receives few Court commitments of juveniles, most of your patients are voluntary, signed in by their parents; isn't that right?

A. Most of them come in under a 403, rather than a 406.

Q. Most of them, as you testified, are people whose family can afford $120.00 a day, plus additional costs; is that right?

A. Yes, either because of personal monies that they have or health insurance that they have of one form or another.

Q. So, you do not have the experience with lower middle class or lower class people who form most of the patients in our state hospital system; is that right?

(177) MR. ROTH: Objection, your Honor.

It's not been established that lower socio-economic backgrounds are the primary persons who are in the institutions.

MR. FERLEGER: I think the Court can almost take judicial notice of the fact that people in state hospitals are not the people who can afford the $120.00 a day that the Institute charges.

JUDGE GIBBONS: No, I don't think I can. Sustained.

Q. Dr. Tashjian, you testified that 90 to 95 percent of the juveniles who are sought to be admitted to the Institute object to being there—

A. To being brought in there.

Q. To being brought in there?

A. Yes.

Q. Now, Dr. Tashjian, what proportion of those juveniles do you feel are competent to voice an objection?

MR. ROTH: Objection, again, your Honor.

I am sorry, it is misleading. However, Dr. Tashjian testified approximately 99 percent voiced an objection.

JUDGE GIBBONS: Well, 99, 95, of those who voice an objection, what percentage in your opinion are competent?

(178) THE WITNESS: I don't know what either of you mean by "competent." I'd like to answer that question, but I would like a clarification of what you mean by "competent."

Q. With regard to the individual case that you were going to testify about and with regard to your institution's responses to the interrogatories, are you aware of the fact that your institution noted "yes" or "no" with regard to the question of competency?

JUDGE GIBBONS: I think you have to show that to the Doctor.

MR. FERLEGER: Certainly.

JUDGE GIBBONS: In the second place, I think his objection to your question is well taken.

Do you mean competency in the legal sense or in some other sense?

Q. Dr. Tashjian, by "competency," I mean competency to object, whether that juvenile had the capacity to voice an objection and know that that person was objecting to being in the institution.



A. Okay, I am aware—competency in medical or psychiatric sense, that the person's disturbance was not such so that there was extreme confusion or extreme disorientation of thought. In that regard, I would say that they were competent.

(179) Q. How many were competent; what proportion?

A. Just scanning over the list, I would say the majority were.

Q. Dr. Tashjian, adults also object to being in mental hospitals; isn't that correct?

A. Yes.

Q. And, a certain proportion of those adults are competent in the sense we have been using it and another proportion are not competent to object; is that right?

And, Dr. Tashjian—

JUDGE GIBBONS: Just a moment. When you nod your head, the court reporter won't pick up that. He can't see you.

Please respond audibly.

A. Could you start again, so I will know what I am—

Q. Dr. Tashjian, you just nodded your head affirmatively to the question of whether or not some proportion of adults who object are competent and some proportion are incompetent.

A. Yes, from a medical and psychiatric standpoint.

Q. When adults object to involuntary commitment, you understand the law, do you not, the law in Pennsylvania is that they are entitled to a commitment hearing under Section 406; is that right?

A. Yes.

(180) Q. Dr. Tashjian, is it not possible that—

MR. FERLEGER: Strike that.

Q. Dr. Tashjian, you testified that participation in Court hearings weakens an already weakened family situation and that in those family situations—this is with regard to juveniles—there is already verbal violence or physical violence.

Now, I take it that your testimony is that in many of these cases, we don't have a typical, normal, stable family; is that right?

MR. ROTH: Objection, your Honor.

I don't believe that Dr. Tashjian has testified that a hearing weakens an already weakened family situation.

MR. FERLEGER: I have notes of three separate people and I think the record will indicate what his testimony is.

JUDGE GIBBONS: I recollect that he did so testify.

JUDGE BRODERICK: It is my recollection. He may not have testified in those exact words but that is the impression I got.

Let's ask him if he so testified.

THE WITNESS: My recollection is that I did testify that way.

(181) JUDGE BRODERICK: Very well.

Q. You will agree that these situations, these families who were in this turmoil, who seek to have a child admitted to the hospital, you would agree these are not



the normal, stable, healthy families from a psychiatrist's point of view?

A. I would have to qualify that in the sense that the impression can get around that families of disturbed adolescents are monstrous in their deviation from the norm.

I would qualify it by saying that families can have any one of us as parents, that family structure can be weakened by crises, can be weakened by family crises, can be weakened by crises among one or more of the family's members in the family during this time. I don't want the Court to have the impression that families of disturbed adolescents are beyond the pale. If that distinction is clear, that then I would say, yes, that families of disturbed adolescents are often themselves disturbed.

Q. Dr. Tashjian, I want to show you a piece of paper marked plaintiffs' Exhibit 8.

MR. FERLEGER: I have three copies for the Court.

JUDGE BRODERICK: All right.

(182) JUDGE GIBBONS: Plaintiffs' Exhibit 8 for identification?

MR. FERLEGER: Yes, your Honor.

Q. Do the photographs in plaintiffs' Exhibit 8 for identification accurately reflect facilities at your Institute of Pennsylvania Hospital?

A. Yes, they do.

Q. Now, Dr. Tashjian—

A. Tashjian.

Q. Excuse me.

In plaintiffs' Exhibit 8, you notice a list of activities that are available at the Institute.

Would you read that list to us and indicate whether that list is accurate?

MR. ROTH: Objection, your Honor.

I find this questioning is irrelevant.

MR. FERLEGER: I am willing to explain, your Honor, that the purpose—

JUDGE GIBBONS: We know your purpose. You are making the point that the facilities at the Institute are not typical.

MR. FERLEGER: The further point I wish to make, your Honor, is with reference to Dr. Tashjian's testimony that children once they get there don't want to leave; that the reason may be that because the situation (183) is so much more attractive and so much more playful than their own homes—

JUDGE GIBBONS: I don't think you need to pursue this any further.

MR. FERLEGER: Okay.

JUDGE GIBBONS: I have made the point that this private institution is more luxurious than state institutions.

MR. FERLEGER: No further question, Doctor.

JUDGE GIBBONS: Mr. Roth?

MR. ROTH: Just a few questions, please.



*Redirect Examination*

BY MR. ROTH:

Q. I believe Mr. Ferleger indicated on cross-examination that he sought you as a witness; is that correct?

A. Yes, it is.

Q. Why did you not appear as Mr. Ferleger's witness?

A. Well, I weighed very carefully both sides of the case at hand and decided that my own philosophy, my own professional beliefs lay more on your side than on his side.

MR. ROTH: No further questions, your Honor.

JUDGE GIBBONS: Doctor, is it fair to say that respectable psychiatric opinion exists which would (184) differ from your own as to the issues in this case?

THE WITNESS: Yes. Yes, it is, sir.

JUDGE GIBBONS: From the medical or psychiatric point of view, rather than from a due process point of view, is there any medical or psychiatric reason for distinguishing between adolescents and young adults for purposes of a precommitment hearing?

THE WITNESS: Are you defining an age point, sir, in the distinction?

JUDGE GIBBONS: Suppose you define an age point. I think the law defines the age point as 18.

THE WITNESS: Well, if we say adolescents are 13 to 18 and young adults from 18 up to 25, yes, I think there are medical and psychiatric reasons for making such a differentiation along the lines which

I have sketchily presented Monday, that it's presumed in general—and certainly there are exceptions in both sides of 18—that a young person by the time he would have reached his 18th birthday, will have navigated the major issues of his developing into an autonomous person and developing a personal sense of identity which is separate and distinct from that of his family.

It is presumed that he will in a psychological sense have reached maturity and be able to make judgments in his own regard.

(185) JUDGE GIBBONS: I suppose you would testify that for the under 13's, it is a fortiori case that they have not reached that state of development?

THE WITNESS: I don't understand the term, sir.

JUDGE GIBBONS: Let me ask it this way.

Would you make the same distinction between young adults and children under 13?

THE WITNESS: Yes, I would, because the child under 13 has much less developed psychologically than the adolescent.

JUDGE GIBBONS: Thank you, Doctor.

MR. FERLEGER: If it please the Court, for the purpose of the photographs Dr. Tashjian has identified, I move the admission of plaintiffs' Exhibit 8.

JUDGE GIBBONS: For what they are worth, it will be admitted in evidence.



(Whereupon, the brochure referred to above, was marked plaintiffs' Exhibit 8 in evidence as of this date.)

MR. ROTH: Dr. Miller.

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DEREK HARRY MILLER, sworn.

THE CLERK: Would you state your full name?

THE WITNESS: Derek Harry Miller.

JUDGE GIBBONS: Mr. Roth, would you please (186) keep your voice up today. We had a little difficulty hearing you on Monday.

MR. ROTH: Yes, your Honor.

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*Direct Examination*

BY MR. ROTH:

Q. What is your profession, please?

A. I am a physician and psychiatrist.

Q. Are you licensed to practice medicine and psychiatry?

A. Yes.

Q. Where are you licensed?

A. I am licensed in Michigan. I am licensed in parts of Canada. I am licensed in Great Britain and Northern Ireland and various dominions.

Q. What medical schools are you a graduate of?

A. Leeds, England.

Q. Where did you intern?

A. I interned at Leeds University and another internship in Canada.

Q. Where did you perform your residency?

A. In Canada and a residency in the Menninger Foundation, Topeka, Kansas.

Q. What is your medical specialty?

A. Psychiatry and in particular adolescent psychiatry.

Q. What specialized training have you received in the field of child psychiatry and adolescent psychiatry?

(187) A. When I was a resident in Topeka, we had a special course in child psychiatry. We did not, in those days, have a special course in adolescent psychiatry.

Adolescent psychiatry is a relatively new subdivision of child psychiatry or psychiatry as a whole and I would have to say that my learning in adolescent psychiatry was one which I guess I sort of led the field in with a group of other people and that I and some other psychiatrists, in the 50's, started to work very significantly with adolescents.

There had been some work before 1939, but not very much.

Q. Doctor, are you a diplomat of any Board of Psychiatry?

A. Yes, I am a diplomat in Great Britain in that I am a member of the Royal College of Psychiatrists.

I also have a higher medical qualification in psychiatry. That is to say, in Britain, you graduate in medicine with an M.B.

I have also an M.D. It is like a Doctor of Medical Science in this country. It is sort of one-up on the standard medical degree, if I may put it that way.

Q. Doctor, have you ever taught psychiatry?

A. Yes.

Q. Have you ever taught adolescent psychiatry?



(188) A. Yes, indeed.

Q. Where have you taught adolescent psychiatry?

A. I taught adolescent psychiatry in England at various colleges of the University of Sussex, Oxford, Cambridge and at the Tavistock Clinic which is a private non-profit-making foundation in England which is run by the National Health Service and is unique in the world.

In this country I teach at a number of universities. I teach at a regular basis at the University of Michigan.

Q. What is your current position?

A. What?

Q. Where is your current position and what is it?

A. Currently I am chief of the adolescent service at the University of Michigan in the Department of Psychiatry. I am associate chairman of the Department of Psychiatry.

Q. Have you authored any psychiatric articles or books which have been published.

A. Yes, a great many.

MR. ROTH: At this time, your Honors, I would like to introduce into evidence Dr. Miller's Curriculum Vitae, which I have marked as defendant's Exhibit 11.

JUDGE GIBBONS: Would you show it to (189) Mr. Ferleger?

MR. ROTH: Yes.

JUDGE GIBBONS: It will be admitted.

(Whereupon, the Curriculum Vitae of Dr. Miller was received in evidence and marked defendants' Exhibit 11 as of this date.)

JUDGE GIBBONS: I hear no objection; is that correct?

MR. FERLEGER: That's correct.

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*Continued Direct Examination*

BY MR. ROTH:

Dr. Miller, how long have you been practicing child and adolescent psychiatry?

A. Since about 1955.

Q. Does your practice include family psychiatry?

A. I don't believe you can treat adolescents without also treating families.

Q. Doctor, throughout this hearing, the terms "child," "infant," "youth," "adolescent," and "juvenile" have been used interchangeably.

Would you please tell us when these terms come into being in connection with human development?

A. Yes, broadly, many of these terms as you know, as is always the case in the English language, are used multiply.

One looks at infants as human beings up (190) until the age two. The word "child" is used, interestingly, sometimes for people up to the age of about 18. Although I think from a medical point of view it probably makes more sense to talk about a child as being a human being up until the age of puberty. "Adolescence" is a stage of development and within that age which is crudely considered to cover the teenage years, there are at least three developmental periods which are sharply defined.

There is a period which lasts about three years in which we are responding to the physical changes of puberty. If you are going to put age norms on, this period ends



at about 14, 15. At about the age of 14, 15, in Western society, generally human beings begin to get interested in a fairly significant way in things that go on outside the family. Generally, the great flush of growth is over.

There is another stage of human development which is middle adolescence, a period in which we are learning to get a sense of ourselves and that lasts about three years and during this period of human development, we are beginning, as it were, to ease ourselves away from our families, although, interestingly, we get very conformist to family norms.

The 15, 16, 17 year old, roughly in this period, is not rebellious at all. They are really very (191) conformist and the last phase of adolescence is one of the periods which is not related to physical growth, and that is a peculiar development associated with our society in which we give people an interesting moratorium. We say, "You must train for certain adult roles in society, but while you are training for these roles in some way, we insist on treating you as if you were not yet adult."

For example, we do this with money; we do this with responsibility about marriage, and so on. So you get a rather prolonged period called "late adolescence," in which people learn to cope with the identity they have already got. Within this period there is a fluctuating relationship to families. That is, through the pubertal period, I would say that in terms of human development, you'd have to say that the family-peer relationships and extra parental-adult relationships are all extremely significant and the family needs to be reinforced in its values for the child by what adults and social networks who are not in the family say about the family, if I make the point.

After the age of 15, a healthy—15 is arbitrary because it may be 17 in some people—after the age of 15, the family as it were is a very necessary back cloth against which development will take place. Having had your healthy family hopefully, about the time (192) you are 15 or 16, you are ready to launch into society somewhat, but you still need to check back, if I can put it this way, with your family.

Now, with children or adolescents who are psychologically disturbed, the family relationships clearly are different. Insofar as adulthood is concerned, there have been interesting definitions of it. One definition is, which I think is nice, by the time you are an adult you are able to predict the likelihood of your prebehavior insofar as it will affect your future possibilities. Or, by the time you are adult, you are able to tolerate being frustrated without necessarily inflicting pain on other human beings. You are adult when you are able to hold your worries and hold your anxieties and not make other people suffer, because of your psychological pain.

Q. Are adults and adolescents psychologically the same?

A. No, they are psychologically quite different.

Perhaps a good demonstration of this would be the issue of the relationship of human beings to time. For example, an adult, and I am talking about a healthy adult, generally has a fair concept of the future. An adolescent is still rather present oriented.

Now there are different developmental rates in men and women. Women reach adulthood chronologically a year or two before men. So, for example, you constantly (193) get into trouble on campuses when young couples



live together as they currently do in that the women often, they have a great sense of the future and they say and feel, if you really loved me, you would want to live with me forever. The young man of 18, 19, in this late adolescence phase still doesn't have a great sense of the future and they are very much wanting things here and now and get anxious, but people start talking about what you do now will affect you or should go on for a very long time. There are many examples.

Q. You have talked in terms of the normal adolescent and adult.

How would that be viewed in terms of the abnormal or the disturbed, if you will, adolescent and adult?

A. There is a very important point about disturbance, that is never ubiquitous in a personality. We have parts of our personality which may be turbulent and cause pain. We may on the other hand have very many healthy parts. It is conceivable, although I trust not, somebody in this courtroom somewhere in their heads can be quite crazy, but there would be no way to know this. It would be that they are showing us the healthy side of themselves.

What we would have to do and this is the grossest generalization, the more adult we are the more (194) we have a healthy functioning personality in terms of being able to be realistic and sensitive, imaginative—not to inflict pain and so on.

If I might, one of the issues which came in an earlier question is relevant to this. The need of adolescents to say "no" to hospitalization is part of being fundamentally enough healthy. An adolescent is striving to be healthy even if they are disturbed, so there are some parts of the personality which are quite healthy and they are struggling

to be independent, to be separate, to be all these sort of things.

So when somebody says to them, "Go into a hospital," they must say, "No," if they have any health at all, because if they don't say, "No," it is like abandoning the ship and it would be like agreeing that I am only a lost, weak, pitiful human being and if you have got any health at all, you are not going to do that.

Q. What is the role made of, of the family in connection with the development of the child in adolescence?

A. The question is frightening in how big it is.

I would say broadly speaking this:

The family needs to provide that sort of loving care and consistency which we require in order to grow. Very specifically, insofar as the development of the sense of ourselves is concerned, our parents, the way (195) they react to each other, the way they react to us, are the models on which we build our personalities. That is to say, we get a perception of our father and mother and both consciously and not consciously, we say, "I would like to be like that." And up until we reach puberty, boys and girls, as you well know, are quite happy often to say, "Yes, I would like to be like my father." Once we reach puberty, when we are trying to separate ourselves which is the process that really begins seriously at puberty and is a very complicated one, particularly boys, go through an elaborate period in which they say, "No. I don't want to be like my father at all. He is square; he is dull."

While they are going through that phase, they are busy looking for adults who strangely they see as being like their father. So they say, "I don't want to be like



my father;" but on the other hand they will find some school teacher hopefully, some minister who they like very much and they will say, "I would like to be like him," and they don't often realize that man in many ways is perceived by them as being similar to their father.

There is a complicated process of modeling in human development which starts with your family relationships and then moves out from your family relationships and what is very important for children is that the models (196) be dissonant. If they are, then the adolescents get very confused. If for example, as can happen, if I might use an example from Britain, if a lower socio-economic class boy or girl gets a scholarship and goes to an English public school which you know is an English private school, the models that they get in the English private school, which is a boarding school, are so different from the models that they have from their parents, that they then get into real confusion about who they are and what they are, particularly if the school staff doesn't support the parents in the way they behave.

Then, the youngsters are really thrown into a real confusion as to who shall I listen to.

Q. Doctor, let's assume the parent brings his child to you. Now, what procedures do you utilize in determining whether or not that prospective patient requires hospitalization?

A. There are really two broad things one can look at, there is the acute emergency which I think is pretty obvious, in which if a child appears—now I am using the word "child" loosely; I am talking about somebody up to the age of 18. If a child appears in any acute crisis which

means that they are being dangerous to themselves or dangerous to other people, then there is no argument about it, we admit them if we have a bed.

(197) We have a policy in our hospital of open admissions and if we have a space we will admit someone. So if it is an acute emergency that presents to our emergency room, we will admit the person. I can go into greater detail because sometimes people come in having made suicidal attempts and they will say they don't need to be here. So, merely being in acute danger to oneself and acutely dangerous to others does not stop an adolescent from saying he wants to be out.

General routine is something like this. We get children referred to us by parents directly. Sometimes by the juvenile court, sometimes by parents via some pressure from the school system, pediatrician or another psychiatrist. Before we will admit, we try to assess and then often these youngsters come with a recommendation for admission and on the day of admission, we will of course try to assess whether the admission seems one, indicated, and two, whether we think that the request is being made to us and that we are the place to be helpful, because sometimes, people will ask for us to take people in and we know we cannot be helpful and then, we will not admit. By the way, although we are a state facility, we differ slightly from the other state facilities in Michigan, in that we can say, "No." This is because we are a teaching hospital, as well. But in a general (198) way, we try to do this:

We try to say to ourselves, "Would this human being be more help-able in our hospital or out of it?" That is one question we ask ourselves.



The other question we ask ourselves is, "Would he be completely unhelp-able if he were out of the hospital altogether? "

Now, that might sound an odd thing to say, but sometimes, we have to admit youngsters to our hospital because they come from the Upper Penninsula, and everybody who knows Michigan knows that is a very long way off and it is too far to travel, so sometimes we get youngsters brought to us and we will admit them for assessment because there is nowhere else for them to go and this puts a particular responsibility on us, I believe and always of course, those boys and girls say, as one would expect, "I don't really want to stay. Let me go home." We will admit boys and girls sometimes under conditions which would certainly not fit the adult commitment laws in Michigan. For example, if we see a boy or girl and if I may use this clinical example, who has been brought to see us, because they are failing in high school and we discover that their high school day consists of moving into the parking lot at a quarter to eight in the morning with some peer and a joint, which is a stick of (199) marijuana, and smoking that and they go on smoking in the high school throughout the day, and this I regret is not as unusual as it ought to be, eventually, you get youngsters who are thoroughly dependent psychologically on marijuana, for example. These boys and girls are not help-able as outpatients, because if I may use the vernacular, they are stoned. If I may be technical, they are intoxicated all the time and you can't relate to these boys and girls while they are intoxicated, so you have to admit them.

As they dry out, you can also begin to get to know them. This is not a cause for commitment of adults, it is

a particular one with adolescents, so we would admit a boy or girl like that.

We would admit a girl to our hospital for example, who was being highly promiscuous, although her other difficulties might not be so catastrophic.

Suppose you have a 14 year old who is being inordinately promiscuous, and in her need to be mothered and cuddled is moving rapidly from boy to boy, frankly collecting cuddling with intercourse the price she pays for it, that child is not help-able as an out-patient, because out-patient treatment always presupposes that the youngster will be able to make a meaningful emotional relationship with whoever tries to treat them and it (200) always presupposes that they will in some way contain their troubles and anxieties to deal with them with the therapist who may be a doctor or social worker or what-have-you and if adolescents are able to go on hurting themselves all the time in this sort of way, we will tend to say, "Admit them," because there is no other way in which we can protect their development and I think the issue with adolescents is different from the issue with adults, because adolescents need treatment sometimes in hospitals to protect their developmental aspect.

Adults, it seems to me, may need to be in a hospital, but generally society adopts the attitude with adults, "We will require you to be in a hospital if we think you are doing certain sorts of things that worry us," but with adolescents, it is an issue of need which is a great deal more complicated.

Q. Doctor, are you aware of the Sections 402 and 403 of the Pennsylvania Mental Health Act?



A. I might get a little muddled about them, but generally I am aware of them.

Q. Are you aware of the additional safeguards for juveniles?

A. Yes.

Q. Could you please tell us, professionally, of what you think of that two-step process?

(201) A. I think it is fine. I have no problems with the two-step process. If I were the receiving psychiatrist, by the way, I would be presenting myself to the child more in terms of trying to make a relationship with them; this is what I want the youngster to feel, that I was trying to make a relationship with them; that I was trying to show them the sort of facilities we have got, which hopefully might be helpful to them in our hospital, where we are, and I think that is as well-staffed as the Pennsylvania Institute, nearly, but physical facilities are awful and really they turn you off in this reception process.

I explain to the youngsters, among other things, what sort of physical surroundings we have and at the same time I would be doing this, I would be assessing whether I thought they really needed to be in a hospital, under some of the terms I have defined.

Parallel to my seeing the youngsters, we always have a professional person see the parents, because there is a funny conflict of interests between adolescents and their parents. Sometimes it isn't helpful if the person who sees the youngster also sees the parents.

We have one of our professional colleagues in our hospital, the day they come in, and by the way, this is a legal obligation in Michigan, they have to be (202) physically examined and so we would do all that and so pretty

much they would be spending a number of hours in the hospital while we are assessing them.

Now, actually, for convenience sake, what happens is, that we start to hotel them on our ward while we are doing this, because they have to have lunch somewhere in all these sort of things. We won't ruthlessly send somebody into town. So the hotelling such as it was, is still going on. It is not limited in our hospital.

Q. Do you feel that psychiatrists and parents operate in a conspiracy to institutionalize or hospitalize their child? Are you aware of any occurrences of that?

A. Yes, I am aware of occurrences because when I became a resident in psychiatry, one of the first things I did working in a state hospital was to happen to be in a ward full of chronic patients and I found an old lady of 45, and she was old before her time, who had been admitted to that hospital when she was 19 for no reason I can establish. She seemed to have been admitted because she had a temper tantrum. I have never in current practice ever come across this.

With the shortage of facilities for adolescents it seems to me inconceivable this could happen, because everybody treating adolescents is in a situation of turning youngsters away.

(203) To my knowledge and I don't know about this state, but getting an adolescent hospitalized in Michigan is an horrendous difficult task because there aren't enough spaces.

Q. Doctor, it has been implied that children are admitted to institutions for the wrong reasons and to protect them a judicial hearing should occur prior to admission.



How would you feel about having a judicial hearing prior to admission?

A. Let me make a point.

I am not against the law and I strongly feel the law should protect the rights of children.

I personally see it as a question of timing. It seems to me the problem is something like this: If a child is going—suppose a child is going into a hospital and on the way he says, "No, I don't want to." That is what one would expect the child to say. That, as I would see it, is the youngster's attempt to say, "I have some autonomy. I have some independence." For the youngster to be sat on with due respect to the Court, by the law and told with the whole majesty of the law, "You must go into the hospital," I fear would be terribly crushing.

That the paradox of the situation is as I would see it, we want to protect the child's right to (204) say, "I don't want to," because that represents health. We don't want to sit on the child's right to say, "I don't want to," because that crushes them and the worst situation you can be in in trying to help an adolescent is to have a passive youngster who won't struggle, because they have given up and, quite frankly, I would be very anxious if the law interceded at that point, because you see, the way we protect a child is this:

Suppose we have a boy or girl in our unit who says, "I want out." Now, that boy or girl has the right now in Michigan to go and get a lawyer which he gets, to go before the Court, which he does. Naturally, he goes before our Juvenile Court and we have in fact—it has to be done under our new Act within seven days.

Now, if the boy or girl has got a good relationship with us, which hopefully he has, and I am using "he" for either, we can and do protect him psychologically while he is going through the process. We have a good working relationship with our Juvenile Court judge who does not sit on the youngster if he says , "No."

We work with the families and help them understand that if, as it usually happens, and it usually does by the way, because we don't keep children who we didn't ought to keep. If as usually happens, the judge says to the youngster, the judge says, "You must stay," (205) we have to explain this to the parents as well. We have never had a child yet, and this may be due to I don't know, perhaps our luck or I like to think our skill, we have not had a situation yet in our hospital in which the judge has removed a child who we say ought to be there. But we don't say a child ought to be with us, lightly. I don't know anybody who does, actually.

Q. What kind of effect would a prior judicial hearing, if you will, have upon the family structure?

A. Well, you know, that's an enormous blanket question, but I tend to think it would be hurtful to family structure in this way. To begin with, assessing a family and assessing a child is quite a complicated business. This is rather a roundabout way of answering the question, but I think it is necessary.

When we admit the youngster for examination, we say to the parents and youngster that the admission in the first place is for not more than four to six weeks, and during that period of time, we would expect to know whether we thought we could be helpful ourselves and if we didn't think we could be helpful ourselves, then, we would suggest some other way in which help was necessary.



Sometimes, you don't keep a youngster four to six weeks because it becomes clear that the crisis rather than the emergency, if I may put it in this way, (206) can be resolved in less period than that. I don't know how to assess almost sight unseen whether the intervention of a Court in sort of stage 1 (A) would be hurtful. I suspect it would and to demonstrate how difficult this would be, I will give you the following example.

In our clinic, we will not automatically have the doctor see the child and the parents together, because we think we need to assess whether that would be a helpful maneuver for the child and the parents.

In other words, somebody will see the parents and somebody will see the child and then we will decide, is it helpful.

Now, I don't know, sight unseen, how you can possibly know whether it will be helpful to the child to be seen in this way, because I think the assessment is inordinately difficult anyway. I think the assessment of need which I believe ought to be the criteria for admitting adolescents and children takes an enormous amount of sophistication and takes a great deal of observation and I don't know how a Court could do this.

The other thing is, something like this, one of the problems that adolescents have who are disturbed is their terrible disappointment in people. You know, disturbed adolescents have tried to make relationships with grown-ups and have failed either because of them (207) or the grown-up. If you really want to know a boy or girl and this is common sense, I think, you have got to get them to feel that you are their friend, you are on their side. These sorts of feelings are obvious.

Now, if it is bad enough that the doctor who assessed the boy or girl has done this and disappointed them by, in a sense, abandonning them when they send them on to somebody else, if the child is to be assessed in a Court, it seems to me somebody has got to make relationship with the child to try and make an assessment as to ought they or ought they not.

My concern is that it is a tease for the boy or girl. For example, one of the things that happen in our unit is that young lawyers come to work with the kids who want out and in working with the kids who want out, the kids begin to see the young lawyers as their friends, which is perfectly reasonable and proper and as it should be. The case goes to Court, however, and as far as the young lawyer is concerned, that's it. He is off somewhere else. So even that procedure can be hurtful, so I would be concerned about it being hurtful to the boy or girl. I'd be concerned about it in evaluating the family and although I agree that psychiatrists aren't often seen by children as being helpful, I don't know that the Courts are seen as helpful by children, (208) quite frankly.

Q. Doctor, in connection with that last question, one point I was trying to question you about—

MR. FERLEGER: Objection.

JUDGE GIBBONS: Let him ask the question.

MR. FERLEGER: I was objecting to his explaining what he was trying to question him about. It seems to me it is leading.

MR. ROTH: I will strike that.

Q. How do you value—let me put it this way: How does the child value a family?



A. The child values a family first of all if they value themselves.

Parents who see themselves as good people and as good parents are in fact likely to be valued by their children, which I guess is reassuring. Families, however, also need to be valued by society. It is painful to children, indeed, when society does something to their parents; sometime the parents precipitate it, but then society does something which the child sees as a devaluation of the parent. One of the things society has been careful to do, I think, even though sometimes society has sometimes to punish parents as people in society, they don't generally devalue the parental role unless they see the parents behaving in a way which society (209) sees as hurtful to the child.

Very specifically, society only interferes in family structure, and I believe this is right, when it sees parents doing something which society says, "You cannot do this because you are hurting your child."

I think likely for that to happen, society, you know, as shown by the Courts, tends to demand very sophisticated proof this is so. In Michigan, the law is that if we see a child who we think the parents are abusing we are obligated to tell protective services and if they think we are justified in being concerned will then go to the Juvenile Court and ask for a guardian ad litem to be appointed. I believe quite rightly, the law is quite sensitive about this.

They don't generally cut into family structure.

Q. What type of interference do you think would occur if the hearing occurred for a juvenile prior to admission where the parent is in conflict with the juvenile or the child?

A. It would seem to me that what would be happening would be that a child's statement which I have tried to point out is inevitable, that "I don't want to," is going to be taken by the Courts, I think, and I am not—I think—I am talking about the parents, as meaning the Courts (210) are going to adjudge their worth as parents.

It seems to me there is very little difference in some ways between my child of 14 saying to me, and perhaps I say this because I am a psychiatrist and I don't think being in treatment is that awful, but if my child of 14 says to me, "I don't want to go to this school," it seems to me my role as a parent is to say, "If I believe that it is the right school, you should go to this school," and frankly, if society then wanted to cut in, assuming it was a good school and recognized by the educational authorities, cut in and allow my child, as it were, to hold my parent-ing up, over that sort of issue, it seems to me we are in a very interesting ball park.

Now, I get the feeling that something similar is in this hearing. It seems to me the parents have to make a judgment about the statement of their dependent children. If they are not capable of making that judgment, that seems to me to be a very sophisticated assessment and as I would see it, this is under the guise of the issue of institutionalization; very real questions are being raised about the value of parenthood and I must take a point that if a parent says, "You must go to a hospital," and hopefully, the psychiatrists who have seen the child are competent and everybody is competent and they tend to be I think in this state as in ours, and the (211) Court said, "No," I believe the Court has a tiger by the tail, because the Court in fact has then said loudly and publicly, "You do not have to listen to your parents."



Now, once you are over the age of 15, parents can no longer—I use that in terms of the end of puberty—parents can't control you by force. You know, frankly, a pubertal 15 year old is likely to be bigger than his father and if you wish to control him, you sure as heck can't do it by force. You can do it hopefully because you are respected by the child. Hopefully, 15, 16, 17 year olds will do what we say, because they respect us.

Now, if our children are told, "You don't have to do what your parents say," then we have put them in the situation, I believe, in this very complicated society, where I would remind you that 42 million people move a year, which means they may have no one else in their lives, but their parents; we have put them in the situation of taking anybody away whose opinion they can value and I think that is a very dangerous thing to do.

Q. Doctor, in Pennsylvania, the hearing is provided subsequent to admission for juveniles age 13 to 18, who object—

A. Yes.

Q. —Do you feel that procedure would be harmful to a juvenile?

(212) A. No, providing, as I would hope, that the institutions and the lawyers work responsibly together.

The implications of that statute is lawyers ought to understand something about psychological illness. Psychiatrists ought to understand something about the law, if I may put it this way. I think it is very important that the child does not, as it were, catch an adversary relationship between the lawyer and the treating people, because they will divide and rule, which is not always helpful to youngsters.

I suppose I shouldn't throw in gratuitous comments, but I guess I have the feeling if the law really takes more responsibility for saying a child must stay in a hospital, then, it seems to me, the law will have to take more responsibility for the quality of caring for patients in hospitals.

And, quite frankly, I'd like to see more responsibility taken by society for the quality of care in most hospitals.

I must make a point. I am not against the law intervening in the quality of treatment. I am not against the law supporting a child that is needing to be in treatment, but what I am against is the sort of timing that is being thought of here which I can see only as enormously destructive and not at all helpful.

(213) There is one other issue. We have to be very careful not to label children. One of the things that made me a little unhappy with your law, if I may say it, is you have something called voluntary commitment. If I understood it right and I may not have, because I am not a lawyer, it means that there are certain situations in which you voluntarily accept the label of being mentally ill; am I right about this?

If that is the case, then I think it is deplorable that children should be labeled. One of the responsibilities I would see the Court as having is when they tell children they need treatment, which they may tell them, they should not stick a label on them, saying, "You are crazy," because one of the problems children have if they are mentally or emotionally upset is they don't know who they are and they are all too willing to adopt the label we give them and so if we label them delinquent, they become that way; and if we label them under-achievers, they become that



way; and if we label them crazy, they become crazy; and the responsibility of a hospital is to provide facilities that don't add to the self-labeling quality.

Q. Doctor, do you feel juveniles should be permitted to release themselves and admit themselves as adults, under 402 and 403?

(214) A. No.

Q. Why not?

A. I have no objection to a juvenile admitting himself, providing that in so doing, they are not getting the institution to act against their parents.

You see, there is a very interesting—you know, disturbed youngsters who are trying to assess the value of their parents, play a sort of fascinating maneuver. They will try in all sorts of ways to get people to agree in action, that their parents are no good. So, if say, a 16 year old who is not an emancipated minor, that is to say, he has contact with his parents, lives with them, presents himself for treatment in our hospital, whether it's in-patient or out-patient, we will see the boy or girl once; we will not see them more than once, because we believe that in so doing, we are implicitly agreeing that their parents are not good people and we are not prepared to agree to this.

So, we will not admit an adolescent who is not an emancipated minor, which a different category, who is not suffering from venereal disease which is a different category in our state and which is not drug indicated and excluding those, we will not admit an adolescent under any circumstance without the agreement of his parents and I might add, because of the peculiar financing of the (215) Department of Psychiatry of the University of Michigan, this is not primarily a money issue, because in our state, if the parents can't pay or if the insurance carriers cannot

or will not, we have a state appropriation that picks up the bill. So, it is not an issue of money.

Q. Doctor, there's been some indication that if a child needs help, that under Pennsylvania law, if it is an emergency, he ought to undergo an emergency commitment.

Now, my question to you is:

What kind of crises do you find juveniles—do you find juveniles are relating to when you first see them; are they emergency crises as being dangerous to self or others?

A. Sometimes, they are crises in a sense. Take a boy we got admitted the other day. He had shot himself somewhere in the thumb, had been admitted to the local hospital, alleging that he had been shot by an intruder. The local surgeon was really quite clever and decided that that sort of thumb shot wound could not have possibly been done by somebody else and he was sent down to our emergency room and he was admitted.

On the spot we got a history of five suicidal attempts from him over the year and he still said he didn't want in. What happened was he said he didn't want in and we say, "Of course, you are to come in."

(216) We have never had ever to drag a child into our hospital. The interesting thing is they say they won't, you bow to the fact that they won't and then they come in as you would expect. That is a typical crisis. Typical crisis which causes trouble or emergency that causes trouble is when adolescents have behaved in a way which is acutely murderous, which is regrettably not unusual and that is troublesome because if an adolescent has been violently assaultive in their behavior and then they frighten



people and they come in with a fear around them which tends to be terribly disrupting to adolescent wards, so that is another sort of case, however we might take it.

We won't take for example, youngsters who have murdered somebody, because we don't have the sort of facility that can protect them or society. I should say youngsters who committed homocide. I think I am being technical. Otherwise, we will take youngsters who have physical illnesses, who abuse their own physical illnesses; diabetics who get out of control, epileptics who won't take their medication. We take youngsters who behave with direction in a way which is destructive to them.

We take youngsters who repeatedly run away from home and put themselves in danger by exposing themselves to who knows what and so on.

(217) Admission is always a crisis, you know, because even if everybody said, "We want you to come in," at that moment in time, it is a painful crisis.

Q. Doctor, you indicated in your answer before, that there was a labeling process, as you understand the law to be?

A. Yes.

Q. I question what effect would a prior hearing have had on a youngster in relationship to a labeling process?

A. Well, I think it would give them a very false sense of their own psychological state in a whole variety of ways. If they are labeled so ill that the law says, "You must go to a hospital," I could only leave this to, I think, the imagination of the Court as to the message this is giving.

Heaven help the child if the law says, "You are solemnly—," I don't suppose it would happen, —"Under Section so and so of this Act you ought to be in the hospital," because that means the youngster gets a strange specialness which will not be helpful.

I think the two things to worry about are false labels and crushing children, and of the two, I don't know which I'd be concerned about most. The thing to worry about insofar as the family is concerned is undercutting their roles as parents.

(218) Q. Doctor, if the hearing were held before admission and the juvenile were present, hearing all the symptoms that may require, if you will, his admission, how do you think that would affect the juvenile—how do you feel it would affect the juvenile?

A. One of the important aspects of growing up is privacy. Everybody in this room who has been an adolescent and we all have, or who have adolescent children of their own, know perfectly well that a very important thing for them is to be emotionally private from their parent sometimes. Adolescents do not tell us everything. One of the things that adolescents have to do when they go into treatment is, to some extent, they have to abandon this privacy. They have to let grown-ups in on their private world which normally they don't do.

Normally they keep a great deal of it to themselves. I believe this is a very special responsibility, quite frankly. I believe we should not over-pressure adolescents to tell us too much, too fast, because that's assaultive.

I believe we should have much respect for that private statement, because that seems to me to be important, too. In those cases in which for example, it has been necessary



when a child wanted to go before the Juvenile Court, if we had wanted to say something that (219) the child has said, which he might not want his parents to know, for example, we ask permission and do sort of approach the Court, tell the judge what the child has said with the child's permission and this may be going to happen. There is a real issue of protecting privacy.

The problem is, you know, that adolescents who are psychologically ill are very easily persecuted and they very easily feel the world is attacking and you have to tread on eggshells not to do things they feel would be attacking. Appearing in Court is a very sophisticated business, I would tend to think, particularly if the child is there.

Q. Doctor, do you feel that the age of 18 is satisfactory in limiting a parent or do you feel that that age should be increased or lowered for the juvenile to be able to admit themselves?

A. I never thought when I was a young man that one day I would be thought of as conservative, reactionary and those sort of words.

One of the most deplorative maneuvers Western society pulled was to move the legal age of adulthood back to 18 from 21. Adolescent-like aging is a time of life of transition and a time of life where you cannot fit where people are psychological to chronological age.

Twenty-one was an excellent age of adulthood, (220) because by then, most people have reached physiological and thereafter psychological maturity. By 18, most people—I won't say most people—a significant number of people are still showing signs of immaturity, because for example, they were late developers into puberty. Some people become pubertal at 11 and a whole series of psy-

chological changes take place. Some people don't become pubertal until 16. Very tall people do not become pubertal until they are 16, very often.

People who arrive at puberty at 16 need three or four years to catch up to themselves, and the legal age limit of 18 causes complications for those adolescents who are late maturers. And, unfortunately, it invited middle adolescents to become choleric. One knows they identify with behavior of older adolescents and older adolescents are now in our state allowed to go into bars and this means to 15 year olds that they ought to go into bars and barmen can't tell the difference, and they can receive a fake identity card.

It is a mess, but it's been done.

Q. Are there hearings given in Michigan prior to admission of a juvenile?

A. Only if the juvenile has broken the law and is going to go to a hospital via the Courts. That is, there are some juveniles who have broken the law and may be sent (221) to us or any other psychiatric hospital by the Juvenile Court when it's been established that they have broken the law and the defendants—it is usually the defendants that request hospitalization, and they can be sent by the Court. They are not committed, usually in a formal sense. The Court merely says, you know, "You ought to go be treated in this hospital," and that's done in the Juvenile Court.

Sometimes adolescents who are waived to the adult courts—I don't know whether this procedure takes place in Pennsylvania, it does in Michigan—a 15, 16 year old can be waived to the adult court, depending on the severity of their crime and they may be ordered to the hospital and



be legally committed to a hospital. Those are about the only adolescents in the state of Michigan who are committed because, our law is different to yours and so commitment as such is very rare there.

Q. What happens if a parent wishes to admit his or her child into your institution, and assuming all prior safeguards are met and the juvenile objects, when is the hearing provided?

A. The point I will make is, almost all of the juveniles object in words prior to being admitted. They don't object in action, and then, what happens is, that usually when they get admitted, they are—initial objection tends (222) to go or they do a very interesting thing. They go on saying, "I don't want to be here," but they go on acting as if they do want to be here, which we expect.

For example, I saw a girl the other day who was 15, who I suppose was the most abusive—colorfully abusive child I have seen in a long time, and she was colorfully abuse in the most amusing language and told me in some 50 minutes how she had no intentions of staying in my blankety-blank-blank hospital, and she would run away and she wanted a lawyer and so forth. We proceeded to get her a lawyer who arrived about three days later. When the lawyer came, she said she didn't want him. She left my office; she went from my office to the hospital school. So all the shouting of, "I don't want to," was verbal and not behavioral and that is common.

Q. But, Doctor, after the child has been in the institution, is there any mechanism in Michigan for providing him or her with a hearing?

A. Oh, yes, the child says, "I don't want to be here." We are then obligated to get the child an attorney

which we proceed to do. We have a number of attorneys floating in and then being told by the children they don't want to see them, which is another maneuver they can pull.

After all, you can disturb the law as well as disturb everybody else. But they get their attorney, (223) the attorney comes and explains their rights to them and so on and so forth.

Q. And, what age does that apply from?

A. Thirteen. The law in Michigan is 13 on up and they must be provided an attorney within seven days and you may exclude Saturday and Sunday, I believe—but they must get the attorney within a seven-day period.

Q. In general, then, you are familiar with there being a hearing afterwards?

A. Oh, yes.

Q. When a juvenile objects after he's been admitted, is there any attempt by the institution to coerce him or to provide punishment, rather than provide him with an attorney?

A. I suppose, I would love to be able to say nobody in our institution is ever punitive because punishment is terribly sterile for adolescents, I would think, unless it's applied by people who they perhaps really know love them and they don't really know we love them so we don't punish.

Punishment does not apply as far as we are concerned. I mean I can't guarantee that there is not some member of our staff who has got in under the wire who behaves as they shouldn't behave.

In a general way, I would think punishment (224) was not an appropriate word in our facility, frankly.



Q. Doctor, one last question; it has been alleged that juveniles are in institutions as mentally ill when their actions may only be defined as juvenile delinquency.

A. Sorry.

Q. It's been stated that juveniles are in institutions, because they are supposedly mentally ill when their actions would only be those of juvenile deliquents. They would be considered delinquents.

Would you please comment upon that?

A. As you know, juvenile delinquency is socially defined. You become one when the law says you are, and whether the law says you are will depend on your social class, the ethnic class.

One of the problems is that, typically, adolescents who are in pain show their pain by inflicting pain. That is to say, typically, an adolescent asks for assistance for himself or herself by behaving in a way which society would perceive as painful, so to some extent in that they arbitrarily inflict pain on others to meet their own needs.

Really, all adolescent illness is antisocial, if I may use that phrase instead of juvenile delinquent. It is almost inconceivable for an adolescent to be psychologically disturbed without hurting someone, (225) either his parents, his teachers or himself, if by no other reason, but making them helpless and useless and this is one of the things that adolescents do.

Adolescents get great gratification unfortunately, particularly when they themselves feel helpless. They get a lot of gratification from stirring up people in their environment and one knows this very well. This is not very helpful to them ultimately in helping them. If he requires

psychological treatment, it is more complicated because sometimes clever juvenile delinquents are so terribly successful. It is very difficult to convince a 15 year old and I saw one the other day, who successfully made $24,000 by stealing IBM machines from a variety of offices and then selling them. It is very difficult to convince him that this is an unsatisfactory way of living.

His attitude was, "Don't tell me that crime doesn't pay; it does." He was not very motivated to have anything done. So, to that extent, successful delinquency complicates treatment.

MR. ROTH: I have no further questions.

JUDGE GIBBONS: We will take a five minute recess.

(Whereupon, a recess was taken.)

JUDGE GIBBONS: Back on the record.

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(226) *Cross-Examination*

BY MR. FERLEGER:

Q. Dr. Miller, from your Curriculum Vitae, I notice last year you published an article called, "The Effects of Social Prejudice on Hospitalized Patients."

Now is it your opinion that social prejudice more adversely affects hospitalized patients as opposed to mental patients on an out-patient basis?

A. The article actually was really not about that at all. It was discussing the Eagleton affair and it was discussing the relationship between the behavior of groups of adolescents on a ward and their knowledge of the Eagleton affair, if I can call it that, and the prejudice actually against being a psychiatric patient.



It wasn't the issue of an in-patient or an out-patient. It was frankly, the issue of being aware of the prejudice.

Q. We can agree that there is a tremendous amount of prejudice in our society in being a psychiatric patient.

A. I would have thought still.

Q. Dr. Miller, you testified with regard to adolescents that the need to say no is a rather healthy need because they desire to be healthy or some part of them wants to be recognized as healthy. The same process occurs in adults, isn't that correct?

(227) A. Yes, but I am not sure it is quite the same.

You see, an adult who says no is presumably saying no, one would hope, only out of the conviction that the reality with which he is being presented is demanding a negation. An adolescent says no because a main motive is to say, "I am myself."

I don't think that's a primary motive with adults. I would hope not.

Q. But it is also a motive even—

A. I would hate to generalize about the adult population. I can conceive that some adults would need to say no, because of some inner psychological reason, but I couldn't possibly generalize about everyone.

Q. But, you would make that generalization about juveniles, though?

A. Oh, yes.

Q. But not about adults?

A. That's right. One is in the area that I work in and the other is an area in which I work less.

Q. Doctor, you testified that for the majesty of the law to sit on a child and say, "You have to go into the hospital," would not be proper.

Now, the current state of the law which does tell the child, "The law requires that you must go in;" isn't that also sitting on the child?

(228) A. The point I'm trying to make, it was depending on how it is done and when it is done and who the child is perceiving as helpful and supportive and so on. It is a multi-determined situation.

Q. It's possible then that there could be a situation if the Court was as creative as it might be where we might develope a procedure where the child would see the process as a friendly one rather than as a surrogate one?

A. Social change is always terribly difficult and I would hate to express an opinion about that sort of social change.

Q. Doctor, you testified that the age of 18 is acceptable, though you regret that we have retreated from the age of 21.

Now there is pending in the Pennsylvania legislature and I am sure you have not seen it but it is an attachment to Mr. Roth's documents that will allow children 14 and up to admit themselves into mental hospitals.

Would you agree with that bill and support that proposal?

A. I find it extraordinary. I haven't seen the bill and I find it generally extraordinary that a society which prided itself in its increasing civilization by protecting its children more and more with things like child labor laws and the like should in these subtle and (229) insidious ways as I see it, turn the clock back. It's very remarkable.



Q. Now, you may be aware—are you familiar with Dr. Masterson's book, Teaching and Learning Adolescent Psychiatry?

A. You put me in a terrible spot. I have looked at it, yes.

Q. In his preface he notes with approval that in Georgia, the law now allows teenagers to get psychotherapy on their own volition.

Would you support the law and allow teenagers, however you define them, to get treatment on their own?

A. In the last part of your sentence is the issue.

The issue is, what do you mean by teenagers? I would make the point that if an adolescent is emancipated from his parents, then I would feel quite strongly he ought to be able to seek psychotherapy on his own.

Q. Unemancipated teenagers should not be allowed?

A. I think you are getting into very interesting technical areas.

I might or might not disagree with Mr. Masterson. It is my belief that we as doctors should not behave in a way that the child—that a child could see as taking his parents' role.

(230) The problem is that if a boy or girl comes for therapy and says, "I need therapy. I want it, but my beastly parents . . ." et cetera, et cetera et cetera, when one knows the child is seeing the parent as beastly but they may not be at all.

One of the great difficulties in this whole area is that if you do see a youngster without the parents' knowledge,

it seems to me, professionally, this does not go well. In Britain, there is no problem of patient—

Q. Excuse me, I was not talking about without the parents' knowledge.

The question is whether or not the parent consents; not to do it secretly, but to do it simply with the child applying.

A. I can see no problem if the parent of a child of 17, 18, or 19, says no, because by 17, 18, or 19, depending on the psychology of the child, the psychology of the parent, it might make sense to go along with that.

My general experience is it does not. I generally feel that parents when they say no, are themselves saying, "Please explain to me what this is all about," and so on and so forth.

Q. Doctor, you testified that a full and open hearing with a child listening to possibly private things, could be detrimental.

(231) Do you think that that problem could be cured simply by having some of the testimony heard in the presence of the child's lawyer, but with the child absent?

A. I suppose this is the area of the issue of the child's confidentiality and the keeping of the confidences and so on and this is terribly complicated.

If a boy or girl has only chosen to tell his lawyer certain things, then, it seems to me that the lawyer is entitled or should assume he's been told it all.

Now, I have had a case and situation which I know perfectly well the lawyer has not been told it all. I would not see it as my responsibility to tell the child's lawyer what all of it is.



Q. Can you answer my question which is whether or not a Court could adopt a procedure which might make it less traumatic or not traumatic for there to be a hearing by taking some of the testimony—

A. We seem to be back in the social change area.

Theoretically a Court can do all sorts of things.

Q. You don't feel you are qualified in that social change area?

A. I have done quite a lot of work in social change. I know how terribly complicated it is.

Q. Doctor, you are aware, I'm sure, that in the juvenile (232) delinquency area, some of the reasons they are categorized as that is because they are incorrigible and do not obey parents and they can petition the Juvenile Courts to get the children to obey and if the parents bring such a petition and the Court says the child was not being disobedient to the extent the Court would get involved, isn't that sort of a situation where the Court would be infringing upon the parents' right to demand obedience from children?

A. Yes, and most responsible Juvenile Courts feel this way strongly and if they get into this situation, one of the things they surely do and good Juvenile Courts have attached to them, many social workers, professional assistants and so on, and I think they commonly see this petition—perhaps "commonly" is wrong; I don't know enough—but it is not within my experience for a good juvenile judge if this petition is before him to see this as the representation of a family crisis. Although he may dismiss the petition he may instruct his Court social workers to try and help resolve the family crisis.

Q. I asked if that could not be perceived as the rejection of their proper parenting role—the parents?

A. I am less anxious about the parents' feeling that their role is being rejected than their child seeing that their role is being institutionally devalued. I think they are quite different.

(233) Q. If the Court said to the parent, no, petition denied, couldn't that result in the child's feeling that the parents—you know, "You parents blew it."?

A. I think that is an inevitable conclusion one would reach and I think it would be a sad situation if, frankly, applying the law in an arbitrary fashion, a judge was to say this, not knowing what family disruption he may cause thereafter.

Q. Doctor, you would not want to end the practice of holding hearings for accused juvenile delinquents, would you?

A. Most certainly not. I think they have every right to have a proper hearing as to whether they are guilty of the behavior of which they are charged or whether they are not.

Q. That would be true even—

MR. ROTH: I have noticed on a few occasions the Doctor has attempted to continue with an answer and he has been interrupted.

JUDGE GIBBONS: Would you finish your answer.

THE WITNESS: Yes.

Q. That would be true whether or not the juvenile delinquent had an emotional disturbance?

A. Since a large number of crimes that are committed by juveniles of emotional disturbances, I suppose society (234) says that they must be adjudged in the Juvenile Court.



If I inflict pain on society as a youngster to which society takes such exception to label a crime, then it seems to me that there is a price that's asked and society has to adjudge whether or not I committed the crimes and I believe they should do that.

Q. Now, Doctor, I appreciate very much your comments earlier on the question of timing of this due process and protections for children.

I would like to describe for you just very briefly a proposal that Pennsylvania's Association of Retarded Citizens has made to the Court and see if you would feel that this sort of timing is—

JUDGE GIBBONS: You mean this Court?

MR. FERLEGER: Before this Court.

JUDGE GIBBONS: Would you refer to an Exhibit number so someone in the future would be able to know what you are talking about?

MR. FERLEGER: For the record, I am referring to a document which was docketed this past Friday. I don't have the docket entry number which is titled, "Brief of Amicus Curiae Pennsylvania Association for Retarded Citizens, Incorporated, and National Center for Law and the Handicapped"—

JUDGE GIBBONS: Show the witness that (235) document.

MR. ROTH: Your Honor, I would have to object. I do not have a copy of that. Where are you referring to?

JUDGE GIBBONS: What page is that?

MR. FERLEGER: Page 39 and the next page or two.

Q. It would be just as satisfactory to me, Dr. Miller, if it pleases the Court, that I can just summarize a procedure and see what you think of it.

A. May I mark this copy?

Q. Certainly.

MR. ROTH: Your Honor, I am going to have to object. It seems to me that the issue at hand is whether or not a hearing should be provided prior to the admission of a juvenile and not whether or not this Court should have the function of determining what type of procedure ought to occur, other than recommending a due process hearing or not.

JUDGE GIBBONS: Overruled.

A. I must say, I am most unhappy really about expressing off-the-cuff opinions about something that people really thought out and I am rather distressed to say, "Yes, it looks fine," or "No, it does not look fine."

Q. I am not asking you to do that.

(236) Let me ask you a question, Dr. Miller, with regard to that. That procedure, to paraphrase it, involves having the juvenile and the parent get together with a review board at an institution to discuss the proposed plan of children. The juvenile will be very assured that this is a very serious thing and there will be an atttempt to work out something that is acceptable to the juvenile, his or her attorney and the parents, for a voluntary commitment to be signed by the parents.

This will be an informal hearing, not before the Court, you know, with relatively little formality. Only



if nothing can be worked out in that administrative hearing, will there be a judicial hearing, if the child or the parents objects.

Do you think that such a procedure which avoids, it seems to me, some of your objections about the Court being involved, would be acceptable to you?

A. Do I understand that what would happen is the child would have been admitted to the hospital and he would have been in the hospital for some time and the hospital staff would have worked out a treatment program which seemed to be appropriate for the child's needs—

Q. No, it would be prior to hospitalization.

A. That's impossible.

You cannot work out a program for a child (237) like this prior to hospitalization. It's a naive idea.

We have a hospital school. Children come to us and I guess I have many negative feelings about the American high school system. Children come to us from high schools with statements, for example, that they have failed completely in everything and the note that we will get from the school will tell us absolutely nothing about that child's attention span, ability to be cognizant, ability to achieve imaginatively, et cetera.

Until we placed that child in our school setting and assessed that child's ability, we are completely unable to say what sort of school program the child should have.

Q. If you have a procedure that Pennsylvania law allows for out-patient evaluation, which could take a few weeks, would that improve your opinion as to the feasibility of this proposal?

A. You see, if the circumstance were such that the child was willing to come, that the family situation was not one of maximum—was not stressful, than in a general way, I would imagine that you would prefer out-patient treatment anyway.

You only send a child into a hospital when the stress in the family or the child's inability to contain anxiety is so little that in fact the child won't (238) come, or for example, the child physically cannot because of distances. So, if out-patient assessment is possible, it may well be that in-patient treatment is not necessary. It may be, but it may not be, but I thought we were talking about youngsters who needed to be in hospitals.

This is my unhappiness about this because I have a feeling we can spend a long time at looking at what you mean.

Q. Just to be clear, we are talking about assessing the need and figuring out whether or not someone needs to be hospitalized.

The question is how is it determined whether or not he has to be hospitalized?

A. This is talking about agreeing to a treatment plan, isn't it?

Q. Yes.

A. And I, by the way, very much believe that parents should be told of the treatment plan, should be involved in it, should understand it, et cetera.

Q. Do you feel at the time of admission, there ought to be or after an evaluation, of course, that there ought to be a work-up of the proposed treatment?

A. Treatment plan is not a rigid thing. Treatment plans vary very much on the state of the child. I guess I



am unhappy about answering your question, because it (239) seems to me that there are so many ifs and buts around it, that I feel I am not saying anything constructive.

Q. Let's get on to something else, then, Dr. Miller.

You, in your book, Growth to Freedom, the Psychosocial Treatment of Delinquent Youth, you discussed a residentiai program for offenders or delinquent youths, and in working out this adventurous program of a non-institutional care for delinquents, you discussed the negative effects of institutionalization.

A. Yes, I have great concern about the negative effects of institutionalization.

Q. You spoke about correctional systems and the systems in England, et cetera; is that right?

A. That's right.

Q. You stated, "People who have been institutionalized, that that process tends to produce what has been called an emotional deficiency disease;" is that right?

A. That's right. By the way, I must explain something.

Institutionalization in that sense is being used technically. That is to say, in theory, you become institutionalized, I believe in social terms, if you are merely placing someone in an institution. In a sense you are institutionalizing them. That's not the sense in which this is being used.

Q. I understand. You mean by "institutionalization," (240) the total institution that Goverman described, or the kinds of places that we call mental hospitals and juvenile institutions; is that right?

A. In general.

Q. Without talking about institutions like this Court; is that right?

A. No, I think not.

It may institutionalize us eventually, but—

MR. FERLEGER: No further questions, your Honors.

JUDGE BRODERICK: I would just like to ask one question, Doctor.

I wonder if you had an opinion as to whether some type of a preadmission hearing would tend to encourage or discourage parents from seeking psychiatric help for their children? Had you thought about that?

THE WITNESS: I had not honestly thought about it very much, your Honor. It is terribly hard to say.

In general, parents are understandably, most parents are very reluctant to seek hospitalization for their children—psychiatric hospitalization. They do almost anything to avoid it.

I think in lower socio-economic classes (241) parents do tend to have a conviction of the Court as being hostile, because I think that can be in the culture. I think they find it harder. I think middle class parents who may know a judge who lives next door and have a quite different acquaintanceship with the law, it may not make any difference.

I tend to think the poor and ethnic minorities who are often very paranoid about the law might find it hard.



JUDGE BRODERICK: I have no further questions.

JUDGE GIBBONS: Thank you, Doctor.

(Witness leaves the stand.)

JUDGE GIBBONS: Call your next witness, please.

MR. ROTH: I'd like to call Dr. James Masterson, please.

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JAMES F. MASTERSON, sworn.

THE CLERK: Would you state your name in full?

THE WITNESS: James F. Masterson.

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*Direct Examination*

BY MR. ROTH:

Q. What is your profession, Doctor?

A. Psychiatrist.

Q. Are you licensed to practice medicine and psychiatry?

A. Yes.

(242) Q. Where are you licensed?

A. New York State.

Q. From what medical school did you graduate?

A. Jefferson Medical College, Philadelphia.

Q. Where did you intern and for what length of time?

A. Philadelphia General Hospital for one year.

Q. Where did you perform your residency?

A. The Payne-Whitney Division of the New York Hospital, Cornell Medical Center, New York.

Q. What is your medical specialty in psychiatry?

A. Adolescents.

Q. What do you feel qualifies you as an expert in that field?

A. The time I interned, my training in adolescent psychiatry which was in about 1956, unlike child psychiatry and adult psychiatry, at that time in the development of this specialty, there were no places to be trained as an adolescent psychiatrist; in that sense I did not have a formal training, but I was taught by the best teachers, the adolescent patients. I started a clinic in 1957, an outpatient clinic and started doing research and over the years I have continued that and have contributed a good deal to the literature and text books.

Q. Are you a diplomat of any Board of Psychiatry?

A. American Board of Psychiatry and Neurology.

(243) Q. Do you currently belong to any professional groups?

A. Well, lots of them.

Q. Have you ever taught psychiatry?

A. I have been teaching it since 1956.

Q. What brand of psychiatry do you teach?

A. Mostly adolescent psychiatry.

Q. Where do you teach it?

A. At the Cornell Medical Center since I finished my residency there in 1956, and since '68, I have been in charge of a program for the treatment of adolescents and the teaching of psychiatric residents adolescent psychiatry.

Q. Have you offered any psychiatric articles or published any books?

A. Yes, both.



Q. Are these articles and books related to adolescent psychiatry?

A. Yes.

MR. ROTH: Your Honors, at this time, I would like to introduce as defendants' Exhibit 12, the Curriculum Vitae of Dr. James Masterson.

MR. FERLEGER: No objection.

JUDGE GIBBONS: It may be admitted.

(Whereupon, the Curriculum Vitae of Dr. Masterson was marked defendants' Exhibit 12, in evidence (244) as of this date.)

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*Continued Direct Examination*

BY MR. ROTH:

Q. Doctor, have you ever been associated with an institution?

A. The medical center in which I work, in the sense of a psychiatric hospital; I have been associated with them since 1952.

Q. What hospital is that?

A. The New York Hospital.

Q. Do you recommend hospitalization of juveniles?

A. Yes.

Q. Do you admit juveniles?

A. Well, as the head of the program, of the inpatient program, I am in charge and pass on all patients who are admitted and all who are rejected for admission.

So, I do it all the time.

Q. Doctor, would you please explain to us, when a patient comes to you with his parent, what you look for from the standpoint of the patient, the parent and your own role?

A. When the patient comes, we see him as coming —the adolescent as being the patient and coming to us for an evaluation. Our function is to try to evaluate this problem in the adolescent and come to a decision as to what is the best treatment for him.

In the course of this, we examine the (245) parents and get their reports as to the behavior, examine the adolescent and take whatever other reports are sent in from schools or social agencies and through the process of examination, often will confront and challenge some of the evidence that is brought in by the family and try to come to some decisions as to what is wrong and what has to be done about it.

This may or may not require hospitalization. If we think—Dr. Miller has already indicated some of this—if we think, you know, let's say at the most urgent he is a danger to himself or others, then he will be hospitalized. If he cannot function in the environment, cannot maintain himself in school or manage his relationships with his peers or parents and just cannot function, he will be hospitalized or if perhaps he is suffering from the difficulty of controlling impulses to such an extent that he's gotten himself into all kinds of behavior problems, we will hospitalize him.

In general, hospitalization is probably the last alternative used. First you would think of out-patient treatment and other forms of care and then, if these are not appropriate or do not work, you think of hospitalization.



Q. Doctor, from your experience, do you discover that parents take alternative measures before hospitalizing (246) their children?

A. In general, for the most part, they are very reluctant to hospitalize them for lots of reasons. Part of their reasoning having to do with the interaction between the parents and adolescent.

Whatever function that the adolescent performs in the family system is interrupted when the adolescent goes into the hospital and this creates difficulty for the parents and for this reason, among others, they don't want to hospitalize them and try some other method first.

Q. Do you practice adult psychiatry?

A. I see adults in my private practice.

Q. What are the psychological differences between the normal adult and the normal adolescent?

A. Well, simply stated, the adolescent is in a state of incomplete development and the process of adolescence is one, a process whereby he masters certain tasks, and in the course of that, becomes fully developed and becomes an adult and just to summarize it briefly, the areas in which he does this is, first of all, the area of emancipation, where he emancipates from the family and this really involves two fundamental parameters.

One is, he goes from becoming emotionally dependent on a mother and father to being independent (247) and in the course of this, his values or standards or conscience changes from being more or less a repetition of his mother and father to being an amalgamation of that and other influences that he has had on his own. So, he becomes a new structure and as part and parcel he learns to adopt a heterosexual role and to find a kind of career in life and

all of these, as he tries and experiments, contribute to a sense of his own independent identity which is unique to him and different from everybody else.

In the course of this process, where he has to experiment and try, he is able to cope maybe better at some times than others because of his capacity and environmental demands which go back and forth. At this time one of the key contributors to this successful development, is the function of his parents.

In other words, I think the parents provide a vital, emotional function for the emotional equilibrium of the adolescent at this time for the process of emancipation and becoming independent and they perform this through, in general, stepping in at times when he is not managing with guidance or with control.

Q. Doctor, how does an emotionally disturbed adolescent differ from an emotionally disturbed adult?

A. One of the things that concerns me about this proposed change is that, as different as the adolescent—(248) normal adolescent is from the normal adult, the difference between the emotionally ill adolescent and adult is much, much greater. The reason being and I think this is a common error that everybody makes, because they are chronologically and physically adult, the assumption is made—the assumption is made they are chronologically adolescent, particularly those who come to the point where hospitalization is necessary.

These adolescents are not emotionally adolescent, they are infants. Their emotional development is infantile. Although they are six-foot-four and weigh 250 pounds, emotionally they are two or three years old, and



now, what does this mean in terms of their behavior and their observation? It means that when it comes to their management of themselves, the way they execute their own emotions and deal with their life stresses, it is dominated by a poor impulse control, poor frustration control, poor judgment.

These are all manifested in an inability to do what is essential for an adult and that is to select and choose among those impulses that they are bombarded with—which one they will express—depending on the gratification they may get and depending on the harmful effects if they do. They are left to the anarchy of their impulses. They cannot do this. When the impulse arrives, (249) it must be discharged regardless of the cost. So that, as I see it, in this suit, in which you are taking, as I see it, the authority away from the parent and handing it to the adolescent, you are giving this particular adolescent his civil rights at the cost of his human rights, I think.

His human rights being the right to the developmental influences necessary for his own development, and giving him this choice, it seems to me, must be based on the assumption that he has the capacity to exercise it in his own best interests.

If he had that capacity, I don't think he would be going into the hospital. He does not have that capacity and so, to give him a choice, I think does him a disservice by misperceiving what his basic emotional needs are and treating him as something he is not.

We have a word for it which is kind of fancy. We call it "adult Aphroditing the adolescent," treating him as an adult when he is not really. They respond to this

with a feeling of being neglected and not being seen for what they are.

This is kind of a phenomenon particularly with those who go in the hospital, which is commonly done by the parents in the kid's early life. It then becomes a repetition on a social level of, you might say, a (250) pathological phenomenon which already caused harm in a family at an early childhood level and it's now institutionalizing him and society is going to do what the parents did and have something to do with the harm in the beginning.

Q. When you have recommended hospitalization of the juvenile, do you find that the juveniles are objecting?

A. Yes, they almost always object.

Q. How do you interpret that objection?

A. Well, this, I think, is such a common phenomenon that we see all the time, you would have to conduct your own little experiment to see how true it is and how stereotype it is.

You see the patient during admission and you see, perhaps as little as ten minutes later, him again when you are on the floor. It comes down to the interpretation of the meaning of behavior.

It is not so much what he says but what he means. And if I may backtrack a bit to what I said a moment ago, because he is in this state that he is dependent upon the parent and does not want to change that, adolescents do not communicate their feelings directly and verbally. So that when they are in pain and are having trouble, they express it by an action and very often it can be an anti-social action. They feel at this point (251) that their parents are scapegoating or rejection is an indication that the parents don't care, but they can't verbalize this because this



means an admission that they would like the parents to care, but the parents don't, and they cannot tolerate it. The way they express it is in behavior and this is what brings them into the hospital.

This is a way of relieving the feeling the parent does not care—by forcing the parent to do what is necessary for the adolescent's well-being.

In other words, for the parent to do for the adolescent what he can't do for himself, which is saying, "You have to go into a hospital because you are sick and you need help," and for the parent to do it over his objections and that is why I think he says no.

As I say, it is so common, we prepare the parents after we have done the evaluation and we say—they are terribly guilty. We say, "Are you so guilty about me that if I put the heat on you, you won't do what is in my best interest? Then that means you don't care about me."

So we prepare the parents after we have decided on hospitalization. The adolescent comes back and he will say things like, "I hate you. I'll never speak to you. Don't you realize what you are doing? These people are going to imprison me. I am going to be (252) tortured," and the parents say, "I'm sorry you feel this way, but it is in your best interest." It is a play or charade. This goes on in the office and when we take a kid down on the floor it disappears and you can see the relief on his face and then they start testing us and then they come and tell us what was going on and why they had to do what they did to get the help they needed.

This is why they say no and I think, by the way, that this is why it should be the parent who says, "You have to

go in the hospital," and not the Court. The parent is providing an emotional function vital to the adolescent at that time and I don't think the Court can ever be an effective substitute.

Q. Do you interpret this rejection as a plea for help?

A. The behavior—in other words, the anti-social behavior, we have characterized as a plea for help, as a way of describing why they are doing it, the fact they cannot communicate directly—so their plea for help is indirect. It is so common, that we advise adolescent psychiatrists for example, to not try to force the adolescent to admit how much he hurts and needs help at that time, because it will just drive him away, but to recognize that it is his very behavior which is the plea for help and accept it and start to work on that level.

I have one example that might illustrate (253) this. I saw a boy who is 16 and he was arrested for stealing at a prep school and brought down to my office for evaluation. He told me this story:

When he was 12 years of age, his mother and father were divorced and he went on to live with the mother. Three months before the Christmas vacation he came home to stay with his mother and he and his mother had a fight and his mother kicked him out and said he should go live with his father. He went to see his father and his father was living with his latest mistress in a hotel and had no room for him, and his father put him up in a hotel room and he spent the entire Christmas holiday reading a comic book and watching television and he went back to school and wrote a theme which he was going to do. Then he started stealing articles from homes and he walked by a policeman and started stealing and was apprehended.



The parents were called and he took all of them to his dormitory and his footlocker, where he had carefully wrapped and stored everything, and this is how he got help.

Q. How do you feel about providing a hearing for an adolescent when the parent agrees with the recommendation of the psychiatrist to hospitalize their child?

A. To repeat what I said before, I am against it, (254) is as if their rights are not being respected, for us to act and to demand and require of them all kinds of conscious, verbal things that they cannot do and are not interested in, and it is a kind of vacillation in carrying out the effective role of the parent in dealing with the problem.

He's already made his statement in his behavior; why does he have to go into Court and go through the whole thing again?

Q. How would an unstable set of parents be operating in the best interests of their children?

A. Well, I think every parent of every patient we see can be called unstable, so that it is a more complicated phenomenon. They are all unstable in some ways.

Now, it depends to a great extent on the way in which their instability affects their role as a parent. There are some people who can, for example, be very effective at their work, but when they come home, they're hell with their children. There are others who after the kids go to bed at seven or eight o'clock at night, they are alcoholic all night; for the rest of the day they manage to perform a parental function.

It's a more complicated problem as to whether they are unstable or not. There are several things about this.

Even parents who are quite disturbed are generally (255) not disturbed all the time and even though a child may play, let's say, a pathological role in their life, for the most part, there is always a part where he does not.

It is over and above the fact that they do have problems. They also want to be a good parent; not just because they have this function now to perform, like to be a good lawyer or good doctor, but it seems to me there is something in the human personality because I hear this theme repeated over and over again. Once you have grown up yourself and once you become an adult, and have a child, one of the key motivating forces is you do not want to repeat the traumas on your child that you received yourself while you were growing up, no matter how large or small, so this also motivates them.

Q. Doctor, do you believe there should be different admission procedures for adults than for juveniles?

A. Yes.

Q. Why?

A. It seems to me I have said it already.

For the same reasons. I think they are different and I think we should recognize this difference and it should be reflected in the law just as it is reflected in psychiatry. For example, we now instead of having the adolescents with the adults in the hospital, we have them in their own unit because this reflects their emotional (256) needs.

Q. Doctor, in Pennsylvania, we provide a hearing for a juvenile age 13 to 18 if he objects at, or subsequent to, admission.

Do you feel that hearing is harmful at that time?

A. I think it can be harmful. It's not necessarily harmful. I think it's a different cup of tea than having a hearing before he gets into the hospital, because those



dynamic and emotional functions that I have mentioned have already been performed. The patient has made his statement in his behavior and the parents have responded and that framework has now been set up for treatment and for, you know, dealing with the problem. Once he gets into the hospital and then he wants out or he wants a hearing, the parents are more or less out of it.

So I think it is a different cup of tea. I think—I have often seen it be harmful where they are allowed out of the hospital and don't belong out of the hospital.

MR. ROTH: Your Honors, I have no further questions.

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*Cross-Examination*

BY MR. FERLEGER:

Q. Dr. Masterson, the hospital or clinic that you have been discussing that you work at is the Payne-Whitney Psychiatric Clinic of the New York Hospital?

A. Yes.

Q. That institution, that Payne-Whitney Clinic, accepts adults as well as children?

A. Yes.

Q. And, the total population, adults plus children, is just over a hundred; is that right?

A. Yes.

Q. And, the total number of high school aged kids is about eleven; is that right?

A. It averages about that. Sometimes more.

Q. Do you have children there, younger than high school age right now?

A. No.

Q. Do you accept children younger?

A. No.

Q. And, the cost per day is about $180.00 per day; is that right?

A. Yes.

Q. It's more than the Institute here in Pennsylvania; isn't it?

A. What is that?

Q. The Institute—

A. I know. What is the cost?

(258) Q. $120.00.

JUDGE BRODERICK: That was the charge, not the cost.

MR. FERLEGER: Yes.

Q. How many psychiatrists are on your staff that are mainly concerned with the eleven or so juveniles that you have?

A. Well, we have a rather—maybe a unique arrangement. We have all the residents in training in their second year musing through the program, so that we have at any one time, we will have—if we have eleven patients, we will probably have eleven second year residents.

We will have two third year residents who we call the chief residents, who are administrators of the program and over and above them we have like five graduate psychiatrists who are supervisors.

Q. Did I understand you to say you have eleven patients, eleven psychiatrists who are residents, plus more than five supervisors and administrators?

A. That's right.



Q. Is there any institution that you know of with a greater doctor-patient ratio?

A. No.

Q. Doctor, you heard me earlier ask Dr. Miller—

A. Let me, if I may, briefly elaborate—

(259) Q. Can you wait to elaborate—

JUDGE GIBBONS: If it relates to the previous answer, elaborate now.

A. There is a reason. We have a one-to-one—because of what we are teaching, we are trying to teach intensive psychotherapy which requires intensive contact over a long period of time so they only get one patient, you see, and if they were getting lots of patients, if they had a lot of patients, the ratio would be quite different.

Q. Most state facilities do not involve the teaching of psychotherapy on that long a basis; is that right?

A. That's correct.

Q. Doctor, in the introduction to the book you edited, Teaching and Learning Adolescent Psychiatry, that I mentioned earlier, you note with apparent approval and your words are, and if you'd like to see the book, I have it here for you.

A. Yes, I'd love to. It's been a long time.

Q. To refresh your recollection (indicating), your words are, "In Georgia, the governor has just signed to law a provision that teenagers may get psychotherapy without the permission of their parents."

Do you approve of such a law?

A. I don't know if I approve of it in that form. I do think that they should be able to apply for help without (260) permission of their parents.

Q. Now, Doctor—

MR. ROTH: Excuse me, had you finished with your answer?

THE WITNESS: No.

A. Then, I think what should happen is that at the appropriate moment—in other words, the psychiatrist should be able to see them without having parental permission first. At the appropriate moment in the evaluation the parents should be brought in and hopefully there would be a consensus among them as to the need for treatment.

Q. If there's a disagreement?

A. I would be in favor of a hearing.

Q. If the child felt that the child needed help and the parents said no.

A. And the psychiatrist thought the child needed help a hearing would be in order.

Q. Even though that hearing might conflict within the parents duties and role as a parent?

A. Yes. May I give you the reason because it sounds like a contradition. It isn't.

I think in medicine in general, there is a conservative principle of treatment and that is that you don't do any more than you have to do—you don't take any more risks or take on any more possibilities (261) of danger that you have to take in order to deal with the problem at hand. I don't think the family unit should be disturbed for the reasons I mentioned. However, under certain circumstances which go beyond that, in other words, there will be greater harm in not doing this than in doing it, I think it should be done. That is one of the examinations.

Q. It is true in many cases of children who have emotional problems as one described in your book, Borderline Syndrome. In those cases the parents are not good observers of the child's symptoms; is that true?



A. Yes.

Q. In fact the parents may have been unconsciously provoking the behavior of the child.

A. Yes.

Q. This would apply to the anti-social or acting-out behavior we have talked about?

A. It could, yes.

Q. Now, Doctor, there will also be many cases where the child may be driven to such behavior by the conflicts at home, isn't that right?

A. That also can happen.

Q. Now, there is a phenomenon, Doctor, in psychotherapy which I am certainly not an expert on, called "counter transference," where psychiatrists have difficulty dealing (262) with the conflicts aroused in themselves by their parents' needs and desires.

Isn't it true, Doctor, that in this situation the psychiatrist may become unable to recognize or to explore the patient's conflict in some situations?

A. This is a possibility, sure.

Q. In those situations, the psychiatrist's difficulties in perceiving what is going on can block therapy and result in an improper evaluation; isn't that so?

A. That's true. I'd like to add to that.

It seems to me here, you are not talking so much about psychiatrists, but you are talking about human nature and I think that phenomenon you have described can occur anywhere.

Q. I agree.

A. And—all right.

Q. Doctor, in situations where, for example, you have a schizophrenic evaluation of a child, you have found in your research, haven't you, that usually at least one of the parents has a pathological attitude toward the child; isn't that right?

A. That's right.

Q. And, that very often, the children are resentful and hostile towards parents, so there is a conflict?

A. That's right.

(263) Q. And usually, there is a rather overt conflict between the parents and the child; is that right?

A. That's right.

Q. Doctor, New York law, as you may be aware, allows for the commitment of anyone, adults as well as children, for that commitment to occur on a certificate signed by two doctors; is that the law in New York?

A. Yes.

Q. Do you believe that sort of admission procedure is a proper one?

A. Am I in favor of that for adults, for adolescents or for everybody?

Q. Right.

A. As I understand it, you are able to have them committed on two physicians' certificates for up to ten days when they must have a court hearing.

Q. Are you certain of that?

A. I am pretty sure of it. I am not certain of it.

Q. Well—

A. Yes, I am in favor of it.

Q. You are in favor of it for ten days or you would be in favor of it if it's indefinite?

A. No, not if it's indefinite.



Q. You would not be in favor of two doctors' certificates for indefinite periods?

(264) A. No.

Q. How about for children?

A. The parents should have to perform this function, and if the parents do not, the Courts should.

Q. Having two doctors' certifications for an indefinite commitment of a person under 18; are you in favor of that?

MR. ROTH: Objection, your Honor. I believe he has answered that question.

JUDGE GIBBONS: No, I don't think he did with respect to the people under 18.

MR. ROTH: I think he addressed himself to juveniles under the distinction.

JUDGE GIBBONS: It certainly isn't clear to me.

Another thing that isn't clear is, you have shifted ground from what the Doctor perceives to be the New York statute which has a ten-day limitation and an indefinite stay.

MR. ROTH: We can refer later to what the New York statute says. I am asking the Doctor whether he wouldn't agree—

JUDGE GIBBONS: I want to be sure that the record is clear in each answer.

Q. Let me repeat the question, Doctor, and make it very clear.

(265) Without reference to the particular provision under New York law, would you favor two doctors' medical certifications for commitment of persons 18 or under for an indefinite period?

A. No.

Q. Would you favor commitment of juveniles with two doctors' certifications with the parents' application for an indefinite period?

A. You are assuming here, that the adolescent objects?

Q. That's correct.

A. No, I think he should be put in the hospital and then I think he should have a hearing.

Q. So, you do not feel then, that just because the parents and the doctors want the child in the hospital, that should be enough reason to keep the child in without a hearing? You do feel a hearing should be provided if the adolescent objects?

A. That right.

Q. Even if that objection comes from this adolescent confusion and turmoil?

A. I think, and it has been my experience, and we have had it in our unit, that since it is an integral part of what is wrong with him, this law has given a weapon to this type of thing where he will sign out—

Q. What do you mean?

(266) A. In New York State we have a law that after they are admitted, if they want to leave, they sign a letter and within 24 hours they must be given the services of a lawyer from the mental health commission and either, in three days, we either have to commit them on the two physicians' certificates or we have to let them go.



Q. Do you feel it's destructive?

A. To them, yes.

It's not until they get through the testing phase of their treatment and get into the relationship and start to work on their problems that they realize the function of what they are doing.

Q. How long does the testing phase take?

A. Three months to six months.

Q. You would be in favor of them not getting the hearing until three months or six months later?

A. Yes. You take this rebellious and negativistic testing teenager who is in the first phase of treatment, all you are talking about is why did he did this and that, and once that happens, you get control of the behavior and once he feels he can trust you and he thinks you know what you are doing and he has not met many adults whom he's had the right to feel that way about them, the whole picture changes and he goes back and reviews everything that has happened and I think I have documented that in this book, (267) and he tells you exactly what he was feeling, which he was unable to say before, and he describes these and at this stage in the treatment if he went before a Court I think he knows and is able to act in his best interest.

Q. So, you would feel that Pennsylvania regulations which allow hearings to be requested within a couple of days, that those would also be destructive?

A. I think they could be very destructive.

Q. Doctor, one further question; it is more a request for an explanation.

You stated in your article in the American Journal of Psychiatry in 1967, "Symptomatic Adolescent Five

Years Later," you said, "I consider, unless I can prove otherwise that my patient has a psychiatric illness."

Now, do you feel that other psychiatrists also share that basic presumption of a psychiatric illness unless it is proven otherwise?

A. I think you have to understand that comment in the context with which it was made, and at the time in which it was made. When I first started in adolescent psychiatry, the dominant theme in the field and that's how this paper is an outgrowth of like ten years of research on this question, the dominant theme in the field was when you see an adolescent, most likely, what is wrong with him has to do with the fact, you know, that he is (268) in this growth stage and it is probably due to that and when he gets over that, it will disappear. And, this attitude on the part of adults towards adolescents goes all the way back to Socrates. However, it was in the literature and it was probably by far the most dominant theme. The result being when adolescents came for evaluation, first of all they were difficult to evaluate and also at that time, we didn't know anywhere near what we know now, there's been such a knowledge explosion in adolescent psychiatry in the years I have been in it, so the psychiatrist was feeling insecure.

So what did he say? "Don't worry about Johnny, he is an adolescent, and when he gets over this he will be better," and every year Johnny's pathology is getting worse and worse and at age 22, after five years and he is out of his adolescence, he is now in a state hospital with a very long term.

All right, this was the context and I did the study and found out it was never growth, it was always psychiatric illness. The psychiatrist should not be thinking about growth but he should be thinking about illness, and the burden of proof should be on him to show the guy is not ill.



Q. The burden of proof on the psychiatrist or patient?

A. The psychiatrist.

(269) Q. The psychiatrists should first assume the person is ill and then try to prove otherwise?

A. I think he should—if we are talking about an adolescent, I think he should assume for the purpose of his own intellectual processes that this phenomenon is more likely illness than growth and then rule out illness and then come to the conclusion of growth rather than the other way around.

Q. Just one final question.

The testing phase you described, this process where at first people say, "I don't want to be in the hospital. I didn't act crazy."—do these things— and then after a while they begin to gain what doctors often call "insight" into their behavior; that happens with adults, too, does it not?

A. Sure.

Q. So, you may have for example, and if this is correct, I have had clients that have been involuntarily put into mental hospitals and after a few months of protesting and not getting out, they suddenly say, "Yes, I really am sick;" isn't that right?

A. Yes, certainly.

Q. So, would you feel then, that the law should also, as is said for juveniles, that adults should not be able to request an automatic hearing until after the testing (270) phase for adults is concluded?

A. I would feel what you have there is an adolescent adult and I would hope this is an exception.

This phenomenon is common; it is part of adolescence. It is not the part of the adulthood.

MR. FERLEGER: No further questions.

MR. ROTH: Just one question.

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*Redirect Examination*

BY MR. ROTH:

Q. In the event a parent brings his or her child to you and you recommend hospitalization and the parent objects to it and the child is indifferent towards it, but is definitely in need of care, what can you do to make sure the child receives care?

A. This will depend upon the degree of need on the part of the child.

Q. Let us assume the degree of need is great, where you would feel professionally badly if that child did not receive hospitalization promptly.

A. The first thing I would try to do is work more with the parents so to see if I can get them to accept it.

If I could not get them to accept it, depending on how bad it is, there's a—I can't remember the name. There's an agency you can call and they will send a social worker in to investigate the family and to (271) take a role in this determination.

MR. ROTH: I have no further questions, your Honors.

JUDGE GIBBONS: Thank you, Doctor.



JUDGE BRODERICK: Good to see you.

THE WITNESS: Nice to see you.

(Whereupon, the witness left the stand.)

MR. ROTH: We did not bring the third witness with us today. We anticipated calling him the first thing on October 7th.

JUDGE GIBBONS: You will get one additional witness.

MR. ROTH: We will have an expert and one witness testifying as to the introduction of the effectiveness of the regulations since they have been published in September of 1973.

MR. FERLEGER: I understand that Mr. Roth is referring to the Exhibit that we discussed on Monday, which lists institutions around the state and I cannot see how one witness can be competent to testify to anything except that he made some phone calls.

JUDGE GIBBONS: I notice that you may have an evidence problem. Will you have any reputable testimony?

MR. FERLEGER: No, your Honor. We have (272) given the Court our Exhibits which are already numbered seven—Dr. Armstrong's deposition —and as soon as we get it signed, we will be submitting Dr. Finer's deposition, which the Court has already ruled can be admitted as a trial deposition.

That will be all the evidence from the plaintiffs.

JUDGE GIBBONS: And both sides will be prepared to p:esent concluding arguments on the 7th, and we will finish the case that day?

MR. FERLEGER: Yes, your Honor.

MR. ROTH: Your Honor, if I may, with regard to Dr. Tashjian's Curriculum Vitae, I would like to have that marked as defendants' Exhibit 10, and on October 7th I will be prepared to introduce additional Exhibits for your ruling.

JUDGE GIBBONS: All right.

(Whereupon, the Curriculum Vitae of Dr. Tashjian was marked defendants' Exhibit 10 in evidence as of this date.)

JUDGE GIBBONS: We will recess then, until the 7th.

MR. FERLEGER: Thank you, your Honor.

MR. ROTH: Thank you, your Honor.

(Whereupon, at 12:17 p.m., Court was adjourned.)



## EVIDENTIARY HEARING

Before: Hon. Daniel H. Huyett, 3rd, J.

Third Day

Philadelphia, Pa., October 7, 1974

(10:00 A.M.)

Present:

David Ferleger, Esq., Attorney for Plaintiffs, Mental Patient Civil Liberties Project, Philadelphia, Pa. 19107.

Barry Roth, Esq., Assistant Attorney General, Attorney for Defendants, Office of Legal Counsel, Department of Public Welfare, Harrisburg, Pa. 17120.

(275) (All Counsel being present, the following transpired in open court:)

THE COURT: Good morning, gentlemen.

MR. FERLEGER: Good morning, your Honor.

MR. ROTH: Good morning, your Honor.

THE COURT: It is my understanding from information given to my office last week, that the defendants have no further testimony and if that is the situation, then, we are concerned with closing the record today and determining the admissibility of exhibits, setting a briefing

schedule after the notes of testimony have been transcribed.

Is there any comment from Counsel?

MR. FERLEGER: That is my understanding, your Honor.

MR. ROTH: That is correct, your Honor.

THE COURT: All right, very well.

Perhaps we could determine what exhibits have been admitted and we can start from there. According to my notes, Exhibit P-1 has been admitted; P-4 has been admitted; P-5 has been admitted and P-6 has been admitted.

Also P-8 has been admitted, and on the defendants' side, my notes indicate we have admitted D-10, D-11, and D-12.

Would Counsel agree with me on that?

(276) Are there any others that have been admitted other than those that I have mentioned?

MR. FERLEGER: I don't believe so, your Honor.

MR. ROTH: No, your Honor.

THE COURT: What other exhibits are we concerned with today, gentlemen?

MR. FERLEGER: For the plaintiffs, Exhibits 2 and 3 were presented to the three-Judge Court at our last hearing and I believe Judge Gibbons commented the Court would reserve ruling on plaintiffs' Exhibits 2 and 3.

THE COURT: What are 2 and 3?

MR. FERLEGER: Number 2 I don't see any problem with, because it is part of the final order, stipulated



facts, the Governor's task force on mental health of children and youth. It is their report on the issues in this case and most of that report is already in the record in the final order.

THE COURT: Is there any objection, Mr. Roth, to the Exhibit P-2?

MR. ROTH: Your Honor, we had objected to the admission of that as being irrelevant.

THE COURT: Is that the only reason for not admitting it?

(277) MR. ROTH: Yes, your Honor.

THE COURT: How is this relevant, Mr. Ferleger?

MR. FERLEGER: Your Honor, it is relevant in two senses: One, because it is the report of an official task force of the Pennsylvania government which made a recommendation to the Department of Welfare, contrary to the regulations they adopted.

It is relevant, also, because just on its face, the arguments and the reasons it gives on behalf of its conclusions, it seems to me, may be permissive to the Court.

It is at paragraph 33 of the final order; most of the report is reprinted at that paragraph.

There is no objection by opposing Counsel to doing that.

THE COURT: Is this a matter that the three Judges specifically took up?

MR. FERLEGER: No.

MR. ROTH: No.

THE COURT: Counsel, a moment ago, stated that we would reserve our rulings on P-2 and P-3. Where did you get that from?

MR. FERLEGER: That is my recollection of the last hearing. I believe Judge Gibbons said to me, (278) "Is there any need to rule on P-2 and 3 at this time?" I answered that there wasn't and I believe that he said that the Court would wait.

THE COURT: Your only objection, Mr. Roth, is relevancy?

MR. ROTH: Yes, and if I may, there has been a mistake in that this is not the Governor's task force. It is the task force on mental health in children and youth. It was not directed by the Governor's office. We have numerous task forces within the Department of Public Welfare which are convened to make recommendations to other councils in the department.

Their recommendations are not binding. It is merely advisory and we feel this report is irrelevant.

THE COURT: Is this the report of a private organization?

MR. ROTH: This is the report of a task force that was convened by the Secretary of Public Welfare of the Department of Public Welfare on children and youth. And they report directly to the Secretary of Public Welfare.

MR. FERLEGER: The defendants' second set of interrogatory replies responded that was an accurate copy of the task force report and gave information as to who the members of the task force were and how it was (279) appointed and to whom it made recommendations.



It seems to me an official government report on the propriety of the recommendations as to what are partly in dispute are extremely relevant to this case.

THE COURT: Any further comment from Counsel on P-2?

MR. FERLEGER: No, your Honor.

MR. ROTH: May I, your Honor?

THE COURT: Yes.

MR. ROTH: Thank you.

With regard to the substance of the report, I merely make one observation and that is that the plaintiffs in this lawsuit seek a judicial hearing for every juvenile whether they object or not and in that particular report, it addresses itself to whether or not a juvenile objects. So it is more restrictive than what plaintiffs seek.

I register an objection again, on the basis of the relevancy. Otherwise, we could provide numerous reports of every task force convened and I think it would not do this Court justice in that respect.

THE COURT: Gentlemen, I will take under advisement the admissibility of P-2.

What about P-3; is that the same thing?

MR. FERLEGER: With regard to P-3, there (280) is more of a problem. This is an affidavit which was filed with the Court some time ago, more than a year ago, I believe, when we mentioned it in our proposed final order and Mr. Roth stated he did not know it was in the record.

Dr. Ginsburg, as I told your Honor at our conference in chambers on the final hearing order, is in South America.

He left, I think, the beginning of August and was unable to be here to testify. The content of his affidavit in a way is a statement of his feelings as an expert on the various matters involved in the commitment of children.

We think that this may be of assistance to the Court.

THE COURT: Mr. Roth?

MR. ROTH: Thank you, your Honor.

Again, we objected to this, and first, may I state for your Honor that we had not received a copy of this when it was allegedly sent a year ago and we had brought this to Mr. Ferleger's and the Court's attention when the pre-hearing order had been drafted.

Upon reading that, we would have continued to object had we noted it a year ago. We found it was irrelevant; that the document, itself, could not be cross-examined; and as your Honor well knows, there (281) have been several experts who have testified and we feel their testimony would be the best evidence, since both parties have had a chance to directly and cross-examine those witnesses.

THE COURT: Anything else on P-3?

MR. FERLEGER: I hope Mr. Roth applies the same reasoning to his affidavits.

Nothing more on P-3.

THE COURT: We can't have this admitted by stipulation, in other words?

MR. ROTH: I would not be willing to, your Honor.

THE COURT: I will take the admissibility of P-3 also under advisement.



What else do we have, gentlemen?

MR. FERLEGER: Your Honor, the plaintiffs have two depositions, which by the pretrial order, I believe were ordered to be admitted.

One is the deposition of Dr. Barbara Armstrong, and I guess we should take that up first.

Mr. Roth sent me, and I just received today, a letter objecting to the underlining on about five or six of the pages. I think we can either resolve which lines are to be underlined or I am willing to omit those entire pages so we don't have to waste time.

(282) THE COURT: What is the purpose of the underlining?

MR. FERLEGER: To eliminate colloquy and other irrelevant matters from the deposition.

THE COURT: There is no question on the admissibility of the deposition? Counsel attempted to purge portions which were not of material importance and which we were not concerned with and this is the hang-up; is that correct?

MR. FERLEGER: Yes, there is only seven pages which there is disagreement on, and I am willing to omit those pages, if Mr. Roth is, because there is no necessity to worry about one or two lines.

THE COURT: What are you agreeing to?

MR. ROTH: Your Honor, it is my understanding, according to your order of August 21st, that we would underscore the portions agreed upon—

THE COURT: The underscored portions should be purged and not considered?

MR. FERLEGER: The underscored portions should be considered and those parts disagreed upon we subsequently resolved that by underscoring those parts in accordance with your order.

THE COURT: If you can't agree, it is admitted.

(283) MR. ROTH: Yes.

THE COURT: Can Counsel work this out and file something?

MR. ROTH: I can agree with Mr. Ferleger on admitting those parts that he has just addressed himself to.

MR. FERLEGER: Can we agree to admit the entire pages?

MR. ROTH: That would be fine.

THE COURT: For the record, what is the number of this deposition?

MR. FERLEGER: My copy—I don't have a number on this. Since it has not been admitted, your Honor, perhaps I should give it a number.

THE COURT: Is this a plaintiffs' exhibit?

MR. FERLEGER: Yes. The last one we have is number 6 and number 8 was a brochure from the Institute of Pennsylvania Hospital. So, I believe this may be number 7.

THE COURT: Number 7 is the accreditation manual for psychiatric facilities and number 8 would be the brochure from the Pennsylvania Hospital which was admitted. Would this be P-9?

MR. FERLEGER: Yes.



THE COURT: All right, the Armstrong (284) deposition will be P-9.

MR. FERLEGER: For the record, plaintiffs move the admission of P-9 with the parts that are underlined in the Court's copies to be admitted with the exception of the following pages, all of which are to be admitted: All of pages 11, 28, 30—

THE COURT: Just a moment. 11?

MR. FERLEGER: 11, 28, 30, 55, 64, 67, 68, and page 123. For those pages, the parties agree that the entire pages are to be admitted.

THE COURT: Do you have any comment on that, Mr. Roth?

MR. ROTH: No, you Honor. That is fine with us.

THE COURT: In other words, the entire deposition would be admitted—let me start over again.

The Armstrong deposition is Exhibit P-9 and those parts of that deposition which are underlined are to be admitted and in addition, pages 11, 28, 30, 55, 64, 67, 68, and 123?

MR. FERLEGER: That's correct.

THE COURT: All of that will be admitted in evidence?

MR. FERLEGER: That's correct.

THE COURT: Fine.

(285) (Whereupon, the deposition of Dr. Barbara Armstrong as outlined above, was received in evidence and marked as plaintiffs' Exhibit 9 as of this date.)

THE COURT: What else?

MR. FERLEGER: Plaintiffs have one further exhibit which has been docketed and copies have been sent to the members of the Court. I was told before you came in that the originals are probably in your chambers.

It is the deposition of Dr. Joel Finer, which by the pretrial order was ordered to be admitted. It has been signed and sent to the court reporter for certification and filing and that deposition, which I believe your law clerk has, I move to have admitted.

THE COURT: This is document 80 in the file of the clerk?

MR. FERLEGER: Yes, I believe so.

THE COURT: Deposition of Dr. Joel S. Finer, M.D., taken August 21, 1974.

Any comment, Mr. Roth?

MR. ROTH: No.

THE COURT: Shall we mark this P-10?

(Whereupon, the deposition of Dr. Joel S. Finer, M.D., was received and marked in evidence as plaintiffs' Exhibit 10.)

(286) MR. FERLEGER: Plaintiffs have no further exhibits or testimony in this matter.

THE COURT: All right, thank you.

MR. ROTH: Your Honor, I have one question, if I may, regarding plaintiffs' exhibits.

I am not certain which plaintiffs' Exhibit 7 was.



THE COURT: According to my notes, it is a manual of accreditation for psychiatric facilities.

MR. FERLEGER: That's correct, your Honor. The record will indicate that it is the Joint Commission on Accreditation of Hospitals' new manual on psychiatric facilities for children and adolescents.

Dr. Kandler, I believe, in his testimony referred to it and it was marked for identification only and was not admitted as an exhibit.

THE COURT: In other words, P-7 was not admitted?

MR. FERLEGER: That's correct, your Honor.

THE COURT: All right.

MR. ROTH: Your Honor, we would object to that—

THE COURT: It is not admitted. It is just simply marked. It is not part of the record.

(287) MR. ROTH: Fine.

THE COURT: Plaintiff has nothing further to offer by way of exhibits?

MR. FERLEGER: That's correct, your Honor.

THE COURT: Mr. Roth?

MR. ROTH: Thank you, your Honor.

We have prepared a list of our exhibits which we sent your Honors and Mr. Ferleger and it is my understanding that there is no disagreement and the following can be introduced into evidence:

Defendants' Exhibit 1—

THE COURT: Will you describe briefly each one?

MR. ROTH: Fine.

THE COURT: And at the end of each exhibit, we will consider the admissibility of each exhibit.

MR. ROTH: Thank you, your Honor.

Exhibit 1, your Honor, is the May 31, 1973 questionnare submitted to all mental hospitals, state schools and hospitals regarding impatient psychiatric care. There were numerous questions on that particular questionnaire which were responded to.

THE COURT: Any objection to D-1?

MR. FERLEGER: D-1 is the questionnaire (288) that was sent out in response to the Court's order that plaintiffs' interrogatories be answered and we have no objection to their questionnaire being admitted.

THE COURT: D-1 is admitted.

(Whereupon, D-1, previously marked for identification was now received in evidence.)

MR. ROTH: D-2, your Honor, are the additional procedural safeguards for juveniles admitted to institutions and so labeled and found in the Pennsylvania Law Bulletin, Volume 3, Number 37, adopted September 1, 1973.

There is a mistake on the cover sheet of the defendants' exhibits which I prepared which says September 1, 1974. It should read, "September 1, 1973."

MR. FERLEGER: No objection, your Honor.



THE COURT: D-2 is admitted.

(Whereupon, the so-marked D-2 is received in evidence.)

MR. ROTH: These exhibits were agreed to in the prehearing order. Defendants' Exhibit 3 are the answers to the questionnaire of May 31, which also was agreed to in the prehearing order.

THE COURT: Any objection to D-3?

MR. FERLEGER: No, your Honor. I understand D-3 is the very large volume of responses by each (289) institution about children in mental hospitals and we have no objection.

THE COURT: D-3 will be admitted.

(Whereupon, the so-marked D-3 is received in evidence.)

THE COURT: May I comment that Counsel should meet with my law clerk to make sure we have all the exhibits and they are all properly labeled, since this is getting to be a rather thick record; that we have all that we should have. I would appreciate that very much.

Would you continue, Mr. Roth?

MR. ROTH: Yes, your Honor.

Exhibit 4 is the admission note of Donn Dickel, which I understand there is no objection to.

MR. FERLEGER: There is no objection to Exhibit 4, your Honor.

THE COURT: D-4 is admitted.

(Whereupon, the so-marked D-4 is received in evidence as of this date.)

MR. ROTH: Defendant 5 is the admission note of Alan Moss which I understand there is no objection to.

MR. FERLEGER: No objection.

THE COURT: D-5 is admitted.

(290) (Whereupon, the so-marked D-5 is received in evidence.)

MR. ROTH: With regard to Defendants' Exhibit 6 and 7, which we had alerted your Court to a few weeks ago, we wish to withdraw those exhibits.

THE COURT: Very well.

MR. FERLEGER: Which exhibits?

MR. ROTH: Dr. Kratsa's affidavit of Alan Moss and Dr. Gus Kratsa's affidavit of Don Dickel.

Exhibit 6 would now become patients profiles which were agreed upon in the prehearing order and we have received no objections to that.

MR. FERLEGER: There is no objection, your Honor.

THE COURT: The new D-6 is admitted.

(Whereupon, the so-marked D-6 is received in evidence.)

MR. ROTH: Defendant Exhibit 7 would be the pretrial deposition of Dr. Max Sugar.

MR. FERLEGER: No objection to Dr. Sugar's deposition.

THE COURT: D-7 is admitted.

(Whereupon, the so-marked D-7 is received in evidence.)



MR. ROTH: Your Honor, if I may state (291) for a moment here, with regard to the Curriculum Vitae of the three expert witnesses, as is recalled, we admitted them as Defendants' Exhibits 10, 11, and 12.

However, our numbering is now going to be augmented, since we have withdrawn Exhibits 6 and 7.

Shall we renumber those exhibits?

THE COURT: No, they can remain 10, 11, and 12. It might be confusing to renumber them.

MR. ROTH: Your Honor, shall I reflect what those exhibits were, 10, 11, and 12, if there is any problem?

THE COURT: You might for the record.

MR. ROTH: Thank you, your Honor.

For the record, Exhibit 10 is the Curriculum Vitae of Dr. Levon Tashjian. Exhibit 11 is the Curriculum Vitae of Dr. Derek Miller, and Exhibit 12 is the Curriculum Vitae of Dr. James Masterson.

Your Honor, Defendants' Exhibit 13 is ten other states' admission policy regarding juveniles. In particular, they are the laws of ten other states which we would respectfully request that this Court take judicial notice thereof.

THE COURT: Any objection?

MR. FERLEGER: I don't object to the Court taking judicial notice of any state statutes.

(292) I do object to Mr. Roth selecting which statutes are selected. I don't believe this is a proper evidentiary exhibit, because it does not tend to prove any fact in this case.

THE COURT: D-13 is a compilation of other state statutes. D-13 will be admitted and if you wish to argue any other statutes, Mr. Ferleger, you may do so.

(Whereupon, the so-marked D-13 is received in evidence.)

MR. ROTH: Defendant Exhibit 14 is labeled "Pennsylvania Laws Affording Adults' Rights While Not Visiting Similar Rights Upon Juveniles."

Again, we would request that this Honorable Court take judicial notice of those laws.

MR. FERLEGER: Your Honor, again, I am not sure of the accuracy of the compilation. It is a selection from Pennsylvania Statutes that the defendants have made. I don't know if they are accurate. I don't know if there are other laws which also involve juveniles that have not been included and I think the Court can take its own judicial notice of whatever laws in Pennsylvania exists.

THE COURT: Mr. Roth?

MR. ROTH: Your Honor, Mr. Ferleger has (293) been apprised of this summary as early as March, I believe it was, of 1973, when I attached a copy of these laws to my motion to my memorandum of law and we merely updated them.

The compilation has been prepared with our office and the Attorney General's office. Certainly, if there are other laws we have left out, we would be more than happy to have these admitted, also.

MR. FERLEGER: Let me just note that the exhibit itself is labeled with the labeling consistent with what Mr. Roth has labeled it.



Exhibit 14 is labeled, "New Laws Lowering Age Limit From 21 to 18 Years." So these are not laws not giving juveniles rights. These are new laws passed by the legislature all in 1972, involving lowering of age limits from 21 to 18. That takes us even further afield from this case.

There are laws about engineers having charge of steam boilers and insurance agents and assessment of taxes; laws involving second class cities and incorporated towns. These are those new laws that the legislature passed involving age limits and lowering of age limits. I don't see what this has to do with this case.

THE COURT: Mr. Roth, you are representing (294) D-14 as accurate and correct and you believe relevant?

MR. ROTH: Yes, your Honor. We feel that these laws reflect when one is 18 years of age or older, what he or she may or may not be able to do in accordance with the laws of Pennsylvania, while not visiting similar rights upon those younger than 18, which we feel is a very significant point in this lawsuit.

THE COURT: Well, to resolve the matter, gentlemen, and consistent with my ruling on D-13, I will admit D-14.

If any part of D-14 is not accurate or correct, I assume plaintiff will point that out in plaintiff's brief.

MR. FERLEGER: Thank you, your Honor.

MR. ROTH: Thank you.

(Whereupon, D-14 is marked in evidence.)

MR. ROTH: With regard to Exhibit D-15, your Honor, this is reflected as to how the September, 1973,

regulations are working as of April 2, 1974. At this time, I would like to introduce in accordance with this exhibit an affidavit prepared by Mr. Ralph Phelleps and Mr. Richard Barbush.

If I may explain the purpose of this first—

THE COURT: Yes. Then you may respond, (295) Mr. Ferleger.

MR. ROTH: Thank you, your Honor.

Your Honor, in September, 1973, we published regulations which basically permit juveniles a hearing, age 13 to 18, if they object at or subsequent to admission. Prior to an April 16, 1974 hearing, I had requested the Office of Mental Health to ascertain how these regulations were working. At that time, Mr. Ralph Phelleps, who was in charge of the collection of this particular datum, proceeded to collect the same. He outlines exactly what his procedure is in outlining that data.

He worked jointly with a person from the Office of Mental Retardation. The reason I bring these affidavits and not the people themselves is because I think the people themselves would merely testify as to the procedure utilized.

In other words, Mr. Phelleps, as is indicated, prepared with Mr. Barbush, as is indicated, the questionnaire letter to be sent. That letter was sent to the regional Deputy Secretaries to the attention of the Regional Commissioners. And they in turn notified the superintendent and administrators of the state institutions and subsequently the superintendents of the institutions and administrators delegate a staff member (296) to collect that data. After the data is obtained at the state or private institutions, it



is provided to the appropriate retardation and mental health commissioner who in turn forwards it to Mr. Phelleps' and Mr. Barbush's office, and this will show also the letter drafted by these two gentlemen which was sent out over the signature of Mr. Gregory L. Coleman, the Deputy Secretary and we submit this is an ordinary business practice in Pennsylvania to disseminate or obtain information from our facilities.

We realize the best way to present this would be to bring the person who collected the data from each institution. As I may recall the Court's attention, there are 20 state schools and hospitals and 10 state mental hospitals and 164 private licensed facilities. We would respectfully request that this exhibit be introduced.

THE COURT: Along with the affidavits?

MR. ROTH: Yes, your Honor.

THE COURT: And this is D-15?

MR. ROTH: Yes, your Honor.

THE COURT: If I were to rule against you, how would you then have to get this evidence in the record?

MR. ROTH: I think the only other way (297) to present this evidence would be to bring in the person from the various institutions and I am somewhat dismayed to have to say that.

I did indicate to your Court we would not bring in any other witnesses. We feel this may be an exception to the hearsay rule, if you will, based on the customary practice.

THE COURT: Mr. Ferleger, what comment do you have?

MR. FERLEGER: I have a number of comments, sir.

First, the hearing originally scheduled for this morning before the three Judges was to include testimony by the affiant here, Mr. Ralph Phelleps. I understood Mr. Ross was foregoing his testimony and it was implied to me, at least, there would not be any necessity for that exhibit to be introduced.

Mr. Roth was on notice, of course, because at the last hearing we had with regard to this hearing, Judge Gibbons stated at page 7, on the sixth line or so:

"I think he would be entitled to cross-examine. The summary could go in if you had a witness here that he could cross-examine. I don't think it could otherwise."

(298) THE COURT: This is specifically on this exhibit?

MR. FERLEGER: That's correct.

Further down, Judge Gibbons stated:

"I think you had better produce the witness and lay the groundwork for the introduction of the summary so Mr. Ferleger can cross-examine and object."

I am not sure what customary business practices are and I don't believe an affidavit submitted to a Court can be considered a business record.

In addition, Mr. Roth's summary of the affidavit indicates that we have, by my count, a fifth level of hearsay in terms of this affidavit and the information that it presents. Also, the Court may recall that at an earlier hearing, I indicated that two cases in which I personally represented juveniles who objected were not listed in that summary. So that I, personally, know for a fact that the summary is not accurate or at least I have indications to that effect and I certainly could not agree it could go in.



I don't understand Mr. Roth suddenly presenting this affidavit when he knew that he needed testimony in support of his submission. I also don't see that it is relevant, whether regulations which are (299) challenged work or do not work or whether 20 juveniles object to admission, rather than 35 or 55, seems to me to be not really crucial to this case.

Mr. Roth already has testimony of Dr. Tashjian's about what happens at the Institute of the Pennsylvania Hospital and I have no idea what happens in the rest of the state. I don't believe this exhibit is any help at all, either.

THE COURT: What is the purpose of this exhibit, Mr. Roth? Why do you need it in the record?

MR. ROTH: Your Honor, the Commonwealth merely wishes to show that the regulations are being utilized and that juveniles who object at or subsequent to admission are being afforded hearings.

If Mr. Ferleger is willing to stipulate to that, certainly we will have no need to introduce this into evidence.

THE COURT: Mr. Ferleger is saying this may not be complete.

You are not saying, are you, Mr. Ferleger, that any part of this is inaccurate or correct? You are saying it is not complete; that there may be more cases than indicated in D-15?

MR. FERLEGER: Yes. D-15 indicates every child who objects is given a hearing when under (300) the regulations children may be released.

The cases I know involved children who were objecting and were released because the hospital decided not to go for a hearing and there are a number of cases which have notices as the facts.

I will stipulate a large number of institutions are using the regulations and a large number of juveniles who objected were given hearings. There is no question about that.

MR. ROTH: Mr. Ferleger has indicated that he has represented two clients who objected to institutionalization that are not on this list. Certainly, we are not apprised of that from any evidence being introduced.

MR. FERLEGER: If Dr. Phelleps was here I could examine him about whether he contacted the institutions that were involved in my cases and what their responses were.

It is indicated he got letters from the various places you have not submitted those letters. I have no idea what he is basing his affidavits on.

Your Honor, if I may, I think Mr. Roth is being a little overindulgent in saying that we need 300 witnesses. Mr. Roth could certainly submit to me the written responses from the institutions. He could (301) have done that months ago. He could have said that at the hearing a month ago when Judge Gibbons indicated he would have to bring the witness in.

MR. ROTH: Your Honor, may I?

THE COURT: Well, is there any—can Counsel agree on any of this?

In other words, hopefully, we are closing the record today. If there could be some agreement of some type,



it would be very helpful. I think there are technical problems as Judge Gibbons pointed out at the last hearing. Perhaps Judge Gibbons and Judge Broderick were not aware of the magnitude defendants would have to get this type of information into the record, and it seems that if defendants wish to get it into the record, somehow there should be a way of getting it in.

Is there any area of agreement by Counsel on D-15?

MR. FERLEGER: I don't believe so, your Honor. I understood that the defendant had foregone any further testimony in this case and I don't see that this affidavit is the basis for introducing the alleged facts that they want introduced.

MR. ROTH: Your Honor, we certainly did not, nor would we attempt to mislead your Honor and Mr. Ferleger with regard to our position—

(302) THE COURT: I am not concerned about that. I am sure you did not attempt to mislead anybody. Don't worry about that.

MR. ROTH: Thank you.

With regard to Mr. Phelleps, he can testify only to what is in the affidavit and I thought it would be more expeditious with providing you with the affidavit, indicating what he does in his customary business practice together with my understanding of the rules would be acceptable.

MR. FERLEGER: Mr. Phelleps has no personal knowledge of any of the facts that are in the exhibit which is the summary involved here. Mr. Phelleps sent letters to somebody else who sent them to somebody else and who

sent them to somebody else and it was delegated to a staff person and shipped up on the law.

I don't know if this was regular procedure. I don't know whether Mr. Roth wants evidence to prepare for litigation; whether Mr. Phelleps' normal job includes being an investigator for defendants' Counsel.

I don't believe this is a business record and I don't believe the facts in that summary can be admitted.

MR. ROTH: Your Honor, Mr. Phelleps has sworn in this affidavit to exactly what procedure (303) he generally utilizes in gathering and dispensing information and at my request, he gathered information regarding these regulations. Also, in accordance with the regulations, we had indicated to the public in the Pennsylvania Bulletin, that six months after publication of those records we would ascertain to see how they were working to determine whether or not we would hold public hearings.

So we respectfully request that this data be introduced into evidence and that Mr. Ferleger who does not seem to object to the accuracy as much as its completeness, if he would like to provide more information, certainly we would like to see that information and register if we have any objections to their introduction.

MR. FERLEGER: I don't know whether it is accurate. I know it is incomplete. I don't know how accurate it is.

THE COURT: Well, can Counsel agree that under the new regulations, there are juveniles, who at the time of admission did object and that petitions were then submitted and the patient was committed under Section 406 and this occurred at a number of the state hospitals



throughout the Commonwealth at various locations, as well as other types of institutions, such as private (304) mental hospitals?

MR. FERLEGER: Yes, your Honor.

MR. ROTH: I would be willing to stipulate—

THE COURT: Would this cover the situation?

MR. ROTH: Yes.

THE COURT: Would Counsel so stipulate?

MR. FERLEGER: Yes.

MR. ROTH: Yes, we shall.

THE COURT: Then there is no need to have D-15 admitted.

What else do you have?

MR. ROTH: With regard to our last exhibit, we wish to withdraw defendants' Exhibit 16, which was a summary of Dr. Sugar's pretrial deposition.

THE COURT: That is withdrawn. All right.

MR. ROTH: We have no other exhibits to introduce, your Honor.

THE COURT: Now, there are missing numbers, starting with D-8. There is no D-8 and D-9?

MR. ROTH: That's correct, your Honor.

THE COURT: May the record now be closed, gentlemen?

MR. FERLEGER: Yes, I just want to (305) mention, your Honor, something I gave your clerk this morn-

ing and Mr. Roth. At 9:15, in this morning's mail, your Honor, I received a copy of an opinion by the Supreme Court of Appeals in the State of West Virginia in a Habeas Corpus action, it is dated July 30, 1974, Hardway versus Flowers, and that Court ruled, a juvenile who is committed without a prior hearing and Counsel to a mental hospital, and it happened to be a very good mental hospital, according to the opinion, that that juvenile was denied due process and equal protection in her commitment.

The other matter I have, your Honor, is something that may have been overlooked in the transition from Judge Masterson to your Honor, and that is the motions to file a brief Amicus of the Youth Law Center in San Francisco. It was filed and Judge Masterson never entered an order on their request to file a brief and on behalf of them we move that be admitted.

THE COURT: Any objection, Mr. Roth?

MR. ROTH: I have no objection.

THE COURT: This is document 31 in the clerk's file, dated October 4, 1974, and it is a request to file brief on behalf of Youth Law Center and I will order now that this brief may be filed.

MR. FERLEGER: Thank you, your Honor.

One other matter which I am not certain (306) how the Court wishes to dispose of and that is that I was informed while I was writing my brief that the United States of America, through the Department of Justice in Washington, D.C., wishes to file an Amicus brief which was completed last week and I believe your clerk may now have more up-to-date information than myself; which will be filed with the Court today or tomorrow and I would



request at this time on behalf of the plaintiffs that the Department of Justice for the United States be given leave to file their brief.

THE COURT: Off the record.

(Discussion held off the record.)

THE COURT: Back on the record.

I will permit the filing of the brief by the United States Government through the United States Department of Justice and I understand such brief will be filed within the next day or two.

MR. FERLEGER: Thank you, your Honor.

I would like to discuss the briefing schedule. The notes of testimony will be filed shortly. The court reporter has done a good job in keeping current.

Do you wish to file a further brief on behalf of the plaintiff, Mr. Ferleger?

MR. FERLEGER: I do not anticipate filing any further legal argument unless some new cases come (307) down, but I would like to file proposed findings of fact and conclusions of law within, I would suggest, ten days to two weeks after the transcript is completed.

THE COURT: All right, I will permit you to file proposed findings of fact and conclusions of law within two weeks after the filing of the notes of testimony.

MR. FERLEGER: Thank you, your Honor.

THE COURT: How much time do you need, Mr. Roth?

MR. ROTH: Your Honor, we would like to reply to Mr. Ferleger's brief which we received Friday afternoon,

and also reply to the transcript with proposed findings of fact and conclusions of law. May we ask for ten days after receiving Mr. Ferleger's proposed findings of fact and conclusions of law?

THE COURT: Very well, you may have then ten days after Mr. Ferleger files his proposed findings of fact and conclusions of law to file a brief and whatever else you wish to file and I ask that you also file proposed findings of fact and conclusions of law.

MR. ROTH: Thank you, your Honor.

THE COURT: After the notes have been filed, we will put this down for oral argument before the three Judges. I think we need oral argument here.

(308) Anything else, gentlemen?

MR. FERLEGER: I just want to make clear that my understanding is that or my intention is that I will file my papers after receiving the notes of the evidentiary hearing and I don't expect to wait for this hearing on the evidentiary matters today, because I don't feel that is crucial.

THE COURT: Do you agree with that, Mr. Roth?

MR. ROTH: Yes, your Honor.

THE COURT: All we are concerned with today are the exhibits.

MR. ROTH: I have no problem with that.

THE COURT: You will file your brief within ten days after Mr. Ferleger files his latest brief.

MR. ROTH: Fine, your Honor.



THE COURT: All right, would one of you prepare an order to that affect? Who wishes to do that?

MR. FERLEGER: I will.

THE COURT: Anything else, gentlemen?

MR. ROTH: No, your Honor.

MR. FERLEGER: No, your Honor.

THE COURT: Thank you very much, gentlemen.

(309) Court is adjourned.

(Whereupon, at 10:55 a.m., Court was adjourned.)

DEFENDANTS' EXHIBIT NO. 1

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QUESTIONNAIRE

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Commonwealth of Pennsylvania

May 31, 1973

SUBJECT: Juveniles Admitted or Committed to MH/MR Facilities Under Sections 402, 403 and 406 of the MH/MR Act of 1966

TO: Regional Deputy Secretaries, MH and MR Commissioner

ATTENTION: Regional

FROM: William B. Beach, M.D., Deputy Secretary for Mental Health and Medical Programs

Edward Goldman, Commissioner for Mental Retardation.

THROUGH: Gregory Coleman, Deputy Secretary of Operations

The United States District Court for the Eastern District of Pennsylvania, relative to the case of Bartley v. Haverford State Hospital has ordered the Department of Public Welfare to obtain and submit to the Court the following information:

1) The names and addresses of all MH/MR facilities which provide inpatient care of juveniles (MH/MR institutions, private licensed MH/MR facilities, and psychiatric units not used primarily for emergency detention);



2) The number of juveniles admitted or committed under Sections 402, 403 and 406 of the MH/MR Act of 1966 during the calendar year 1972;

3) The number of juveniles in residence as of May 10, 1973, under Sections 402, 403 and 406,

4) Reason for juveniles' admission or commitment or precipitating behavior warranting admission or commitment;

5) Objection of admission or commitment and/or detention by juvenile patient;

6) Relationship of applicant;

7) Mental status, competency to make judgment at time of admission or commitment; and

8) A copy of each facility's admission policy.

Juvenile is defined as one who is 18 years or younger. In this case those who had reached their 18th birthday as of May 10, 1973 should be included. However, those turning 18 years of age prior to May 10, 1973 should not be included. If the individual is 18 years and one day, he is not considered to be a juvenile.

Enclosed is a form sheet with definitions outlining information required. Please send copies of this form to all facilities listed for your respective Region. For your information, we have enclosed a list of all those DPW facilities from which this information is required. Please note that we have obtained much of this information from the State Hospitals and State Schools and Hospitals. Therefore, you should only be concerned with all private licensed MH and MR facilities and those psychiatric units not used primarily for emergency detention.

It is absolutely necessary that this information be received in Central Office to the attention of Mr. Ralph

Phelleps, Office of Mental Health, Room 303, Health & Welfare Building, Harrisburg, Pennsylvania 17120 no later than July 2, 1973.

If there are questions, you may contact Mr. Phelleps at Telephone #787-5370 or Richard Barbush at Telephone #787-5102.

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INFORMATION SHEET

Admission/Commitment of Juveniles

Definitions/Explanation

Juveniles—Those who are 18 years of age and younger. The individual is still considered a juvenile on his 18th birthday; however, when he becomes 18 and one day, he is no longer a juvenile but is considered an adult.

Number—Do not name the juvenile; use his or her case or file number.

Objection—We wish to know if the juvenile objected at his admission or subsequent thereafter to remaining in your facility. Indicate Yes or No or N.I. for not indicated in records.

Competency—Indicate only if juvenile objected, whether or not the juvenile had the mental capacity to make that judgment—Yes/No. If juvenile's behavior pattern causes him to be negative, indicate negative. If not revealed in chart, indicate N.I. for not indicated.

NAME OF FACILITY:

ADDRESS:

1. Number of Juveniles Admitted During Calendar Year 1972 Under

402 ————

403 ————

406 ————



If possible, indicate number of those remaining at end of year ————.

2. Number of Above That Were Readmissions

402 ————

403 ————

406 ————

3. List 402 Admissions By Case or File Number and Supply Appropriate Information.

*Number; Reason for Admission/Behavior; Objection; Applicant/Relationship; Mental Capacity/Competency*

CONTINUATION OF NUMBER 3. (List 402 Admissions by Case or File Number and Supply Appropriate Information).

*Number; Reason for Admission/Behavior; Objection; Applicant/Relationship; Mental Capacity/Competency*

4. List 403 Admissions By Case or File Number and Supply Appropriate Information.

*Number; Reason for Admission/Behavior; Objection; Applicant/Relationship; Mental Capacity/Competency*

CONTINUATION OF NUMBER 4. (List 403 Admissions By Case or File Number and Supply Appropriate Information).

*Number; Reason for Admission/Behavior; Objection; Applicant/Relationship; Mental Capacity/Competency*

5. List 406 Admissions By Case or File Number and Supply Appropriate Information.

*Number; Reason for Admission/Behavior; Objection; Applicant/Relationship; Mental Capacity/Competency*

CONTINUATION OF NUMBER 5. (List 406 Admissions By Case or File Number and Supply Appropriate Information).

*Number; Reason for Admission/Behavior; Objection; Applicant/Relationship; Mental Capacity/Competency*

6. Attach a copy of your Admission policy for juveniles and adults.

NOTE: For Numbers 3, 4, and 5, if more space is needed please attach extra sheets with appropriate headings.



DEFENDANTS' EXHIBIT NO. 4

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

HOSPITAL Haverford State Hospital

D . . . D . . .

Name
Case No. 10118 Page ———

ADMISSION NOTE: 3/1/73

D . . . D . . . , aged 14, admitted March 1, 1973, on a voluntary commitment to Bldg. #9. His previous behavioral history is complex, chaotic and has caused his family a great deal of concern and conflict. He has also been truant from school and he has refused to cooperate with out-patient psychotherapeutic attempts.

He is oriented in all spheres, he was initially uncooperative but eventually stated his opinion and limited understanding of his past behavior. There is a strong indication that he has a fragile hold on reality issues and seems relatively sad and confused.

Current plan is to admit him and see him as an individual patient and work separatedly at first with his parents. Plans are to use both male and a female therapist for D . . . . Defer competency as patient is not of age to drive.

IMPRESSION:

Adjustment reaction of adolescence.

Gus P. Kratsa, M.D.

cbw
RTS-112 not sent

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
HOSPITAL Haverford State Hospital

Name D . . . D . . .
Case No. Page ———

Present: Drs. Kratsa, Armstrong and members of the Adolescent Service Staff.

NEW CASE CONFERENCE NOTE:

D . . . D . . . was admitted March 1, 1973. D . . . D . . . age 14 demonstrates a very difficult clinical problem. His outline in his admission note was referred for inpatient care by Dr. Bernard Kantor who felt that he was unmanageable as an out-patient and he was also chronically truant from school. During this hospital stay our plan is to someway initiate motivation toward a out-patient therapy and find a reasonable school that D . . . can evolve himself with for his future educational involvement. Our assessment of family process at this time is exceedingly pessimistic. Both of D . . . adopted parents have poor reserve both physically and emotionally and are in our opinion very likely unable to cope with the future demands that D . . . will make upon them upon discharge. We are therefore working very diligently towards a residential placement in a therapeutic facility similar to the Green Bank School which had been recommended to us by an outside consultant.



It was also important during this hospital stay to further assess D . . . neurologic status. Again we recommended that D . . . be evaluated by another neurologist in the community with currently completing his evaluation which will include a repeat of an EEG which was done here at Haverford and felt to be borderline.

DIAGNOSIS:

1. Multiple developmental deviation in multiple dimensions.

2. Unsocialized aggressive reaction of adolescence.

RECOMMENDATIONS:

We are recommending residential placement in a therapeutic school and continued psychotherapy for D . . . for an indefinite period of time. He is currently not cooperating with our program. He is not affectively accepting medication.

Gus B. Kratsa, M.D.

GBK/dmn.

DEFENDANTS' EXHIBIT NO. 5

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
HOSPITAL Haverford State

Name M . . . A . . .
Case No. 9929 Page ———

ADMISSION NOTE

January 10, 1973

A . . . M . . . , age 15 years-10 months, referred from HUP following in-patient psychiatric evaluation. Had been in out-patient treatment at Hahneman prior to HUP admission. Current problem is difficult to assess without admitting A . . . for further observation. He is depressed and suicidal—has been especially pre-occupied with suicide, for the last few months.

Will be admitted to Building 4 with possible transfer to Building 9. Both parents and one of his 3 siblings were part of this evaluation.

(s) G. B. Kratsa
G. Kratsa, M.D.

1s



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
HOSPITAL Haverford State Hospital

Name M . . . A . . .
Case No. 9929 Page ———

NEW CASE CONFERENCE NOTE:

Present: Drs. Armstrong, Kratsa and members of the Adolescent Service.

A . . . M . . . , age 15 was admitted on January 10, 1973 following a transfer from the University of Pa. Hospital Psychiatric Unit. Please refer to the summary of his hospital admission for details of that admission and the reason regarding his transfer to our facility. On admission A . . . was cooperative, demonstrated slurred speech secondary to a great deal of over-medication. The medication was felt to be indicated in order to facilitate his transfer from the Hospital of the University of Pa. to Haverford State Hospital. At the time of admission A . . . was on Tofranil 50 mgm t.i.d., Thorazine 25 mgm t.i.d., Valium 5 mgm b.i.d., Tylenol 2 tablets q 4 hrs. prn headache. Following a review of the clinical material from the Hospital of the University of Pa. including a medical evaluation for Cushings Disease, it was our opinion that a further neurologic consultation was indicated. This was accomplished and at the time of this dictation it was the opinion of the consulting neurologist that there was no underlying neurological disease and A . . . problem was indeed primarily psychiatric. A psychological testing which was completed prior to the time of this dictation demonstrated a very limited capacity in many spheres including ego strength,

academic skills and overall personality development. Our goals relative to his education were therefore set with minimal demands and he was assigned to the small tutoring group rather than the day school. Gradually all medication was discontinued and he was then placed on a small amount of Stelazine at bedtime along with Cogentin and was given prn analgesics for a continued complaint of tension headaches. The plan during the hospital stay was to facilitate his return to his family and to complete his full year with the Haverford Day School Staff.

DIAGNOSIS:

Adjustment reaction of adolescence with depressive features and intellectual limitations and poor impulse control.

(s) G.B. Kratsa
Gus Kratsa, M.D.

GK/dmn.



OPINION—JULY 24, 1975

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

Kevin Bartley, et al.

vs.

Jack B. Kremens, individually and as Hospital Director of Haverford State Hospital, et al.

Before Honorable John J. Gibbons, Circuit Judge, and Honorable Daniel H. Huyett, 3rd, and Honorable Raymond J. Broderick, District Judges

HUYETT, J., July 24, 1975:

OPINION AND ORDER

Plaintiffs have filed this class action[1] on behalf of the named plaintiffs and all persons eighteen years of age or younger who have been, are, or may be admitted or committed to mental health facilities in Pennsylvania under the

[1] On April 29, 1974, we ordered that this action be maintained as a class action but left open the possibility that the definition of the class set out in the text might be amended or altered before the decision on the merits. We now find that this definition of the class is appropriate. We note that this action concerns children who allegedly are mentally ill as well as children who allegedly are mentally retarded.

Pennsylvania Mental Health and Mental Retardation Act (Act). 50 P.S. §§4402 and 4403 (§§402 and 403).[2]

[2] Section 402 of the Pennsylvania Mental Health and Mental Retardation Act of 1966 provides in part:

> Section 402. Voluntary admission; application, examination and acceptance; duration of admission.
>
> (a) Application for voluntary admission to a facility for examination, treatment and care may be made by:
>
> (1) Any person over eighteen years of age.
>
> (2) A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.
>
> (b) When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he may be admitted.
>
> (c) Except where application has been made under the provisions of Section 402(a)(2) and the person admitted is still eighteen years of age or younger, any person voluntarily admitted shall be free to withdraw at any time. Where application has been made under the provisions of Section 402 (a)(2), only the applicant or his successor shall be free to withdraw the admitted person so long as the admitted person is eighteen years of age or younger.

Section 403 of the Pennsylvania Mental Health and Mental Retardation Act of 1966 provides in part:

> Section 403. Voluntary commitment; application, examination and acceptance; duration of commitment.
>
> (a) Application for voluntary commitment to a facility for examination, treatment and care may be made by:
>
> (1) Any person over eighteen years of age.
>
> (2) A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.
>
> (b) The application shall be in writing signed by the applicant in the presence of at least one witness. When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he shall be committed for a period not to exceed thirty days. Successive applications for continued voluntary commitment may be made for successive periods not to exceed thirty days each, so long as care or observation is necessary.
>
> (c) No person voluntarily committed shall be detained for more than ten days after he has given written notice to the director of his intention or desire to leave the facility, or after the applicant or his successor has given written notice of intention or desire to remove the detained person.



Invoking 28 U.S.C. §§1331 and 1343(3) and 42 U.S.C. §1983, plaintiffs ask us to declare §§402 and 403 unconstitutional and enjoin their enforcement.[3]

Plaintiffs contend that in violation of the Fourteenth Amendment to the United States Constitution, they are being denied both due process of law and equal protection of law because Pennsylvania allows plaintiffs and their class to be detained—denied their liberty—in mental institutions without substantial procedural safeguards including the: (1) right to notice; (2) right to a pre-commitment hearing; (3) right to counsel and if indigent appointment of counsel; (4) right to present evidence on

[3] Plaintiffs do not challenge either Section 405 or 406 of the Pennsylvania Mental Health and Mental Retardation Act of 1966. Section 405 permits involuntary detention of persons, regardless of age, under emergency conditions for no longer than 10 days. Section 406 permits involuntary commitment of persons upon petition to the state court of common pleas and after hearing and examination. The person to be committed is entitled to notice of hearing, the right to counsel, and the opportunity and right to present testimony and evidence in his or her behalf and to confront his or her accusers. The court may order outpatient or partial hospitalization instead of in-hospital commitment.

their own behalf; (5) right to subpoena witnesses and documents; (6) right to confront and cross-examine witnesses against them and those who wish to admit or commit them; (7) right to be involuntarily detained only upon a decision of a judicial officer; (8) right to be involuntarily detained only upon a decision that they are in need of treatment, care, or observation.[4] Plaintiffs also contend that the regulations supplementing §§402 and 403 do not cure these sections of their constitutional infirmities because they apply only to children 13 years of age or older, require no pre-commitment hearing, and designate no time by which a post-commitment hearing must be held.[5] In essence, plaintiffs claim that the present procedures do not adequately assure against the mistaken commitment of children who are not mentally ill.

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[4] We are not presented with the issue of what standards are needed for commitment. For an analysis of this question see the recent opinion of J. Hoffman in *Commonwealth ex rel. Charles Finkin, Jr. v. Roop,* Pa. Superior Ct. (1975). Also see, *Bell v. Wayne County,* 384 F. Supp. 1085, 1095 (E.D. Mich. 1974).

[5] After plaintiffs filed this action the Department of Public Welfare, pursuant to Section 201(2) of the Pennsylvania Mental Health and Mental Retardation Act of 1966, adopted additional procedural safe-guards for children admitted or committed to institutions pursuant to Sections 402 and 403. These regulations provide in part:

1. All juveniles age 18 and younger to be admitted to an Institution must be referred from a recognized medical facility Mental Health/Mental Retardation therapist or Mental Health Agency; however, mentally retarded juveniles may be referred by either a pediatrician, or general physician or psychologist;

2. This referral must be accomplished by a psychiatric evaluation and that report must indicate with specificity the reasons that the person requires institutional care; however, a medical or psychological evaluation may accompany the referral of a mentally retarded juvenile;



3. The Director of the Institution or his delegate, shall have conducted an independent examination of the proposed juvenile, and if his results disagree with the professional's opinion, the Director, or his delegate shall discharge the juvenile;

4. The telephone number and address of the juvenile's parents or the person who is requesting admission for the juvenile must accompany the referral;

5. Within 24 hours after the juvenile's admission, every youth who is at least 13 years of age must receive written notification (which he signs) explaining his rights indicating that he will be given a status report periodically of his condition; that he can contact by telephone or by mail his parents or the person who requested his admission; and that he will be furnished with the number of counsel (Public Defender's number; Legal Services) that he can call for representation. An appropriate person shall explain this notice (attached);

6. In the event that a juvenile whose chronological age is 13 or older objects (either orally or in writing) to remaining in the Institution, the Director, or his delegate, if he feels it is necessary for the youth to remain, may continue the institutionalization for two business days during which time he shall notify the applicant and the referral unit so that either party may institute a 406 proceeding. During that same two-day period, the Director, or his delegate, shall notify the Public Defender's Office or notify Legal Services readily available of the juvenile's need for legal representation. If a 406 proceeding is begun during the two-day period, the juvenile shall remain institionalized. If the applicant cannot be located and the Director, or his delegate, feels that the juvenile does not require institutionalization, the Director, or his delegate, shall direct the Base Service Unit to assume responsibility of providing for the juvenile's aftercare. However, if the Director, or his delegate, feels that the juvenile requires institutionalization, he shall direct the Base Service Unit to

In support of their claim that §§402 and 403 are unconstitutional, plaintiffs have submitted brief summaries of the reasons for the commitment of the named plaintiffs and other members of their class to demonstrate that many decisions to commit involve factual determinations requiring substantial procedures to guard against wrongful or erroneous commitment. We rely for our findings on the summaries contained in the final pretrial order which have been stipulated to and on defendants' exhibit numbered eight (8).

The named plaintiffs were either admitted under §402 or committed under §403 to Haverford State Hospital.[6] Plaintiff M.W. was admitted to Haverford State

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file a 406 proceeding within two days after failure to locate the applicant;

7. The juvenile's counsel shall be furnished with the juvenile's evaluation from the referral unit, with a psychiatric evaluation from the Institution, and with a written report of the reasons to institutionalize the juvenile;

8. If the staff member of the facility giving notice to the patient determines that the patient is incapable of understanding the notification, it shall be written on the notification;

The regulations do not provide a time by which a commitment hearing must be held. The Attorney General of Pennsylvania assures us that in cases involving children at least 13 years of age, commitment hearings are scheduled within a short while after the child objects. With respect to children 12 years of age or younger, there is no requirement for a hearing, no less a designated time. Defendants submit that these regulations were not adopted with and towards this litigation and that with or without them, Sections 402 and 403 are constitutional.

[6] By stipulation Haverford State Hospital was withdrawn as a defendant. Haverford is a mental health "facility" under Section 102 P.S. §4102 of the Mental Health and Mental Retardation Act. It receives admissions and commitments of persons including persons eighteen years of age or younger admitted or committed under Sections 402 and 403.



Hospital under §402(a)(2). His mother admitted him allegedly against his wishes when he was fifteen and on December 1, 1972, he informed agents and employees of defendant of his desire to leave Haverford State Hospital. Plaintiffs K.B., S.G., L.L., and V.M. were committed to Haverford State Hospital under §403(a)(2). Plaintiff K.B. was fifteen when his mother committed him against his wishes. He was and still is critical of some of the hospital's regulations and treatment practices. Plaintiff S.G. was seventeen when his father committed him allegedly against his wishes. Plaintiff L.L. was fifteen when her mother committed her allegedly against her wishes. Her difficulties in relating to her mother resulted in her commitment. Hospital records show that she threatened the lives of her mother and sister and that she has a personality disorder. Her parents are divorced and her father is remarried, living in Florida. At the time of her commitment and the time this action was filed, she would have preferred to have been with her father and when she is with him her behavior is excellent. Plaintiff V.M. was fourteen when her mother committed her allegedly against her wishes.

Members of plaintiffs' class have been institutionalized for various other reasons. Patient number 13,173, a moderately retarded 13 year old child, was institutionalized in Polk State Hospital because of very sudden, explosive, rage reactions during which he attacked others and of which he has no recollection. His behavior rather than his mental retardation was the primary obstacle to his return to the community. Patient number 13,212, an

educable mongoloid boy with the capacity to participate in many educable and trainable activities and who can be helped by an active special elementary program in public schools, was institutionalized in Polk State Hospital for a 1 to 2 week period so that the other members of his family could go on a family vacation. Patient number 288, a mentally retarded child, was placed in Western State Hospital because of a poor family situation. The mother of the child did not get along well with the child, and the family was afraid that she would have another nervous breakdown if the child were not placed in Western State Hospital. Patient number 281, a mentally retarded child, was placed in a state institution because she had become a management problem to both her parents and the community. Patient number 15, a mentally retarded child, was placed in Western State Hospital because the child interfered with the routine of the household and disturbed family members. The placement was based on a fear that if the child remained in his home, the mother might break down, the marriage of the child's parents might end in separation, the father's health might fail, and an adolescent daughter might be pushed into a premature marriage to escape an unhappy home. Class members have also been committed to mental hospitals for running away, robbing a gas station, stealing in general, chasing and striking a girl, arson, delinquent behavior in general, truancy, physical ailments such as colitis and weight loss, school phobia, and drug overdose.

At the time this action was filed defendants were all Pennsylvania officials with specific duties under the Act. Defendant Jack B. Kremens as Hospital Director of Haverford State Hospital was charged under 50 P.S. §§4102 and 4203 with supervision and administration of Haver-



ford State Hospital. It was to Kremens or his delegates that application for admission and commitment under §§402(b) and 403(b) of the Act had to be made. Defendant Helene Wohlgemuth as Secretary of Public Welfare of the Commonwealth of Pennsylvania (Secretary) had the power under 50 P.S. §§4201 and 4202(a) to enforce the Act, to make all regulations necessary and appropriate to the proper accomplishment of the Act, and to operate and assign functions to all state facilities. Defendant William B. Beach as the Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania had the general authority to supervise and regulate mental Health facilities in Pennsylvania.

At the outset, defendants contend that since the purpose of the Act is to meet the child's needs through treatment and rehabilitation rather than to punish the child by incarceration for what he has done, the requirements of due process do not apply to the institutionalizing of children under §§402 and 403.[7] Defendants proceed to argue

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[7] A number of defendants in similar cases have raised this argument. In *In re Gault*, 387 U.S. 1, 21 (1966), defendants claimed that juveniles obtain benefits from the informal juvenile procedures which more than offset the disadvantages of denying them the substance of normal due process. The Court rejected this argument holding:

> observance of due process standards, intelligently and not ruthlessly administered, will not compel the States to abandon or displace any of the substantive benefits of the juvenile process.

In *Denton v. Commonwealth*, 383 S.W. 2d 681 (Ky. 1964), cited approvingly by Judge Biggs in *Dixon v. Attorney General of Pennsylvania*, 325 F. Supp. 966, 972 (M.D. Pa. 1971), the court also rejected this argument holding that commitment procedures should

that if we determine that due process applies, we should find that in light of Pennsylvania's interest in protecting the child, preserving the family unit, maintaining the rights of parents to the custody, care, and upbringing of their children, and protecting society, the present statutes and

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be the same in civil commitment proceedings as they are in criminal proceedings. Responding to this same argument, Judge Biggs in *Dixon* stated: "We are unimpressed by the parens patriae argument and strong courts have not been persuaded by it." (Citations omitted.) In *Holm v. State*, 404 P.2d 740, 742 (Wyo. 1965) the Wyoming Supreme Court held:

> No matter how commendable the motives back of legislation for the mentally ill may be it still remains the fundamental law of the land that a person is not to be deprived of his liberty—whether by involuntary hospitalization or some other kind of incarceration—without due process of law.

In *Heryford v. Parker*, 396 F.2d 393 (10 Cir. 1968), the court held that even if the institutionalizing of children is for rehabilitation, the constitutional safeguards of due process must be observed. The court in *Lessard v. Schmidt*, 349 F. Supp. 1078 (— Wis. 1972), was faced with the argument that due process procedures should be relaxed because of a subsequent right to treatment and because the commitment proceedings were civil in nature. After examining the effect civil commitment may have on those adjudged mentally ill, the court rejected these arguments and held that all persons 18 years of age or older being held pursuant to any emergency, temporary, or permanent commitment provision of the Wisconsin involuntary commitment statute, were entitled to substantial procedural safeguards. *Saville v. Treadway*, F. Supp. (M.D. Tenn. 1974) presented a challenge to a Tennessee Statute which permitted the "voluntary" commitment of juveniles by a parent, guardian, or person having legal custody of a mentally retarded minor. While recognizing the services furnished to mentally retarded children by the state, and the efforts in mental rehabilitation of the state, the court held that "where individual liberty is at stake . . . it is absolutely essential that such confinement be preceded by adequate procedural safeguards."



regulations satisfy any due process requirements. Finally, defendants argue that since under §§402 and 403 the parents, guardians ad litem, or persons standing in loco parentis must set into motion the commitment machinery, these persons effectively waive any due process rights of plaintiffs and their class.

## DISCUSSION

Under the constitutional guarantee of procedural due process, we have developed a system whereby a person who may be subjected to a grievous loss of liberty is entitled to adequate procedural safeguards. *Wolff v. McDonnell*, 418 U.S. 539 (1974). Generally, the state is required to provide substantial procedures when there is the possibility of erroneously and wrongfully depriving persons of their liberty by committing them to mental institutions. See, concurring opinion of Chief Justice Burger in *O'Connor v. Donaldson*, 43 U.S.L.W. 4929, 4935 (1975); *Lynch v. Baxley*, 386 F. Supp. 378 (M.D. Ala. 1974); *Lessard v. Schmidt*, 349 F. Supp. 1078, remanded 414 U.S. 473 (1974); redecided 379 F. Supp. 1376 (1974), remanded 43 U.S.L.W. 3600 (May 12, 1975); *Dixon v. Attorney General Commonwealth of Pennsylvania*, 325 F. Supp. 966 (M.D. Pa. 1971). These safeguards attempt to protect persons from an arbitrary or erroneous deprivation of liberty or property, whether that deprivation be imposed for benevolent or punitive reasons. They are "our best instruments for the distillation and evaluation of essential facts from the conflicting welter of data that life and our adversary methods present." They "enhance the possibility that truth will emerge from the confrontations of opposing versions and

conflicting data." *In re Gault,* 387 U.S. 1, 21 (1966). As Mr. Justice Frankfurter has said: "The history of American freedom is, in no small measure, the history of procedure." *Malinski v. New York,* 324 U.S. 401, 414 (1945) (separate opinion) cited by the majority in *In re Gault,* at 21. If we are to preserve our traditional liberty we must scrutinize with care any claim that it is being arbitrarily denied.

In deciding whether the requirements of due process apply in any given case, the threshold question is whether the interest of the complaining party is within the contemplation of the liberty or property language of the Fourteenth Amendment. *Morrissey v. Brewer,* 408 U.S. 471, 481 (1971). The particular question here is whether or not a child's interest in not being institutionalized under §§402 and 403 is safeguarded by the Fourteenth Amendment. Defendants would have us find that because Pennsylvania is acting as parens patriae and not as an adversary, and because the admission and commitment proceedings are civil, not criminal, in nature, plaintiffs and their class may not complain of the deprivation of procedures available in criminal cases. Such a finding would ignore that the child is involuntarily removed from his home and familiar surroundings and is committed to an institution where "[he] suddenly faces the regimented routine of ward life and daily confrontation with state employees, however capable, rather than family and friends." *In re Ballay,* 482 F.2d 648, 669 (D.C. Cir. 1973). As the Court of Appeals for the Tenth Circuit noted in *Heryford v. Parker,* 396 F.2d 393, 396 (1968):

> It matters not whether the proceedings be labeled "civil" or "criminal" or whether the subject matter be mental instability or juvenile delinquency. It is the likelihood of involuntary incarceration whether for punishment as an adult for a crime, rehabilitation as a juvenile for delinquency, or treatment and training as a feeble-minded or mental incompetent—which commands observance of the constitutional safeguards of due process.



Defendants' contention also ignores the stigma associated with civil commitment which some commentators and courts have noted may render civil commitment a more lasting abridgement of personal freedom than imprisonment for commission of a crime.[8] The child who faces

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[8] Loss of liberty is in issue not only when a person is physically confined. The Due Process Clause also affords protection "where a person's good name, reputation, honor, or integrity is at stake because of what the government is doing to him." *Wisconsin v. Constantineau,* 400 U.S. 433, 437 (1971); *Board of Regents v. Roth,* 408 U.S. 564, 573 (1972); *Goss v. Lopes,* 419 U.S. 565 (1975); *Donalds v. O'Connor,* 493 F.2d 507, 520 (5 Cir. 1974), vacated and remanded *O'Connor v. Donaldson,* 43 U.S.L.W. 4929 (1975).

While we hope that society is moving in the direction of viewing mental illness in the same light as physical illness, we cannot ignore the reality that many in our society view mental illness with disdain or apprehension. See *In re Ballay,* 482 F.2d 648, 668 (D.C. Cir. 1973), where the court noted that, "[e]ven accepting recent medical advances, current studies clearly indicate the fallacy of contending that most people view mental illness as a disease similar to any physical ailment of the body" and that it could not "ignore the striking example of this attitude displayed by news stories and public reaction to disclosures made by a recent vice-presidential aspirant." In *Pennsylvania Association for Retarded Children v. Commonwealth of Pennsylvania,* 343 F. Supp. 279, 293 (E.D. Pa. 1972), Judge Masterson, writing for the three judge court, held that in light of *Wisconsin v. Constantineau, supra,* due process requires a hearing before retarded children may be denied a public education because of the stigma which our society unfortunately attaches to the label of mental retardation.

the possibility of being physically confined for an indeterminate period with all of the ramifications of such confinement clearly has an interest within the contemplation of the liberty and property language of the Fourteenth Amendment.

Having decided that due process applies, we are left with the questions of what process is due, *Morrissey v. Brewer, supra,* at 481 and whether this process may effectively be waived by plaintiffs' parents, guardians ad litem, or persons standing in loco parentis.[9] Before discussing the process here, we shall first consider whether or not parents, guardians ad litem, or persons standing in loco parentis may effectively waive the personal rights of children, since such a finding obviates the need to decide whether the present procedure violates the constitutional right of plaintiffs to procedural due process. The question is both difficult and unique. Viewing the issue as whether or not a parent may effectively waive personal rights of a child when the child objects to the waiver creates a confrontation between a liberty interest of plaintiffs we find constitutionally protected and the consistently recognized authority of parents to direct the rearing of their children. *Ginsberg v. New York,* 390 U.S. 629, 639 (1968).

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[9] As yet, the Supreme Court has not decided whether the child's parent, acting on behalf of the child, may effectively waive constitutional rights of the child. In *Heryford v. Parker, supra,* the court, in holding that the Due Process Clause applies to an involuntary civil commitment procedure, recognized that special problems may arise with respect to the effective waiver of rights by minors and mentally deficient persons. Finding that there was no express attempt to make such a waiver, the court did not decide the issue.



We presume that in most instances parents, proceeding in utmost good faith, acting for the child, in the child's best interests, properly guide, protect, and control their children. In *Wisconsin v. Yoder,* 406 U.S. 205, 231, 232 (1971), the Supreme Court, stating that it was not determining the proper reconciliation of possible competing interests of parents, children, and the state, noted that:

> The history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children. This primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition.

Also, see, Justice Stewart's concurring opinion at 237. We are not unmindful of this tradition and its importance to the structure of our society, *Ginsberg* at 639, and if we could find that in all instances parents act in the best interest of their children, we might also find that parents may waive constitutional rights of their children. Unfortunately, as such a graphic example as parental child abuse illustrated,[10] this is not the case.[11] In deciding to

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[10] See Memorandum and Order of Judge Urbom filed June 4, 1974, in *Horacek, etc., v. Exon, et al.,* Civil Action No. 72-L-299 (D.C. Neb. 1974). The claim before Judge Urbom was that the named plaintiffs were in a state hospital because their parents put them there. Responding to the argument that plaintiffs were in the hospital voluntarily because their parents placed them there, Judge Urbom held that "parents cannot deprive their children of constitutional rights—rights of the children vis-a-vis the state."

[11] Dissenting in *Kent v. United States,* 401 F.2d 408, 416, n.4 (D.C. Cir. 1968), the now Chief Justice Burger noted:

> Lawmakers in recent years have been sensitive to the need to make civil commitment difficult recognizing the dan-

institutionalize their children, parents, as well as guardians ad litem or persons standing in loco parentis, may at times be acting against the interests of their children. With this in mind we must agree with Judge Judd in *New York State Association for Retarded Children,* 357 F. Supp. 752, 762 (E.D.N.Y. 1973), that, "in the absence of evidence that the child's interests have been fully considered," parents may not effectively waive personal constitutional rights of their children.[12]

Remaining is the question of what process is due. Due process is flexible in that a determination of what process is due cannot be made without an evaluation of "the precise nature of the government function involved as well as of the private interest that has been affected by government action." *Cafeteria Workers Union v. McElroy,* 367 U.S. 886, 895 (1961). At a minimum, it requires that "deprivation of . . . liberty . . . by adjudication be

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gers of relatives "farming" out their kindred into mental institutions for motives not always worthy.

In *New York State Association for Retarded Children, Inc. v. Rockefeller,* 357 F. Supp. 752, 762 (E.D.N.Y. 1973), the court stated:

> [t]here may be a fundamental conflict of interest between a parent who is ready to avoid the responsibility of caring for an abnormal child, and the best interests of the child. Murdock [Civil Rights of the Mentally Retarded: Some Critical Issues], 48 Notre Dame Lawyer at 139-143.

[12] This finding does not mean that when considering whether or not to institutionalize a child, the state should ignore the opinions and observations of the child's parents. Rather, the committing authorities should listen carefully to parents who live with and observe the child on a daily basis for they very likely have invaluable information concerning their child.



preceded by notice and opportunity for hearing appropriate to the nature of the case,"[13] but the formalities of the procedure however, "the timing and content of the notice and the nature of the hearing will depend on appropriate accommodation of the competing interests involved."[14] Because courts cannot determine what process is due without evaluating the competing interests, the content of due process shifts as the interests shift; "[t]he required degree of procedural safeguards varies directly with the importance of the private interest affected and the need for and usefulness of the particular safeguard in the given circumstances and inversely with the burden and any other adverse consequences of affording it."[15]

As previously discussed, plaintiffs' interest in being free from the wrongful and unwarranted deprivation of their liberty is substantial and they argue that the present procedure does not adequately protect this interest. The state's interests are three fold. It has an interest in the mental health of children (parens patriae), an interest in preserving the family unit and maintaining parental authority over children, and an interest in confining, for the protection of society those persons who pose significant danger to the community (police power). The state has decided that its interests require a relaxed, informal procedure, and it argues that a more formal procedure will substantially interfere with its interests. To strike a proper

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[13] *Goss v. Lopez,* 419 U.S. 565, 79 (1975), citing *Mullane v. Central Hanover Trust Co.,* 339 U.S. 306, 313 (1950).

[14] *Goss v. Lopez,* at 579, citing *Cafeteria Workers v. McElroy,* 367 U.S. 886, 895 (1961); *Morrissey v. Brewer, supra,* at 481.

[15] See, Friendly, J. "Some Kind of Hearing", 123 U. Pa. L. Rev. 1267, 1278 (1975).

balance between the competing interests of plaintiffs and the state, we shall analyze them in the context of each procedural right of which plaintiffs claim they are being deprived. This will give us the content of the process which, at a minimum, is due before plaintiffs may be institutionalized for treatment.[16]

## PRE-COMMITMENT HEARING

A decision to institutionalize a child is often a difficult yet necessary decision for a child's parent to make. It is generally pursued only after all other alternatives have proven futile. The state has an interest in seeing that a procedural system will not deter parents, already faced with this difficult decision, from attempting to institutionalize children who are in need of treatment only mental institutions can provide. Further, to protect society and the individual child, the state has an interest in the immediate detention of children who may be dangerous

[16] As we have already noted, due process is flexible; the Constitution mandates no specific code of procedures. We are aware of the problems facing courts when they attempt to fashion procedures protecting interests within the liberty and property language of the Fourteenth Amendment and we are sensitive to the claim that courts are "good at deciding cases, bad at drafting legislation. . . ." See, Friendly, J. "Some Kind of Hearing", supra. When presented with claims of constitutional dimension, however, we are constrained, when legislative bodies have failed to act, to find means of enforcing the constitutional rights being denied. Our action is not intended to pre-empt the state which is free to develop its own safeguards so long as they are as fully effective as those which we set out. See *Miranda v. Arizona*, 384 U.S. 436, 490 (1966); *Morrissey*, at 490.



to themselves or others. See, *Lessard v. Schmidt*, at 1092; Developments in the Law—Civil Commitment of the Mentally Ill, 87 Harv. L. Rev. 1190, 1275 (1974).

Balancing these substantial interests of the state with that of the child, we find that plaintiffs are not entitled to a pre-commitment hearing. As the Supreme Court has found with criminal cases, however, we find that, for the protection of the child, he is entitled to a hearing before an unbiased tribunal within a reasonable time to test whether there is probable cause to believe institutionalization is necessary. *McNabb v. United States*, 318 U.S. 332, 343-344 (1943); *Morrissey v. Brewer*, at 489 (1971); *Lynch v. Baxley*, at 388. In no event shall detention of the child in the absence of a probable cause hearing exceed seventy-two (72) hours from the date of the initial detention. See, *Lynch v. Baxley*, at 388; *Lessard v. Schmidt*, at 1091.[17]

## POST-COMMITMENT HEARING

If the conclusion of the preliminary hearing is that there is probable cause for believing the child needs institutionalization, the child is entitled to a post-commitment hearing before an unbiased tribunal on the need for commitment. A delay after the probable cause hearing is permissible. This delay will allow the child to adjust

[17] In *Lynch v. Baxley*, at 388, the court held that emergency detention without a hearing on its appropriateness may not, in the absence of a probable cause hearing, exceed seven (7) days from the date of the initial detention. In *Lessard v. Schmidt*, at 1091, the court held that a probable cause hearing must be held within forty-eight (48) hours from the date of the initial detention.

to his new surroundings and will allow both the state and the child time to prepare for the post-commitment hearing to come. It will also allow the state time to examine and diagnose the child adequately. These reasons do not, however, justify a prolonged period of confinement without a final determination on the need for institutionalization and should not exceed a two-week period. A two-week period will afford all parties an opportunity to prepare adequately and properly their positions with hope of ascertaining that which is best for the child.[18]

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## NOTICE

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The opportunity to be heard is fundamental to due process of law. *Grannis v. Ordean,* 234 U.S. 385, 394 (1914). Without notice of that which is to transpire at a hearing "sufficiently in advance of any required hearings so that reasonable opportunities to prepare will be afforded," *In re Gault,* at 33; *Lessard v. Schmidt,* at 1092; *Lynch v. Baxley,* at 388, the right to be heard has little significance. *Mullane v. Central Hanover Tr. Co.,* at 314. To counterbalance this substantial interests of plaintiffs the state argues that by delaying treatment and traumatizing the child, the requirement of notice will aggravate the child's mental illness, interfere with the state's police power, and disrupt family harmony. In *Gault* at 21, the Supreme Court refused to accept the state's fear of trauma

[18] Until the legislature acts to establish an unbiased tribunal to conduct the probable cause and final hearings the present facilities of the Commonwealth court system shall be used for these hearings.



as a justification for limited procedures. The Court stated that the observance of due process standards will not necessarily compel the states to abandon the substantive benefits of the juvenile process. Further, as Judge Tamm noted in *In re Ballay,* 482 F.2d 648, 664 (D.C. Cir. 1973), the fear that added procedural requirements will produce trauma presupposes that the person who faces commitment is mentally ill. Likewise, while procedural safeguards assume that not all persons who face commitment need actually be committed, the argument that procedures will interfere with the state's police power and disrupt family harmony assumes that the child is dangerous to others and comes from a family in harmony.

Keeping in mind that due process assures against error, we find written notice required, including the date, time, and place of the hearing, and a statement of the grounds for the proposed commitment. See, *Lynch v. Baxley,* at 388; *Lessard v. Schmidt,* at 1092. Neither the state nor plaintiffs have an interest in committing to mental institutions children not in need of institutionalization. Notice should not shield children in need of institutionalization from commitment and treatment but rather should protect children not in need of institutionalization from wrongful commitment and improper deprivation of their liberty.[19]

[19] Obviously this notice may be meaningless to some children. We, therefore, find that until some other procedure is established this notice shall be sent not only to the child but also to the Clerk of the Court with jurisdiction and shall be forwarded to the child's attorney. The child's attorney shall be in receipt of the notice at least forty-eight (48) hours prior to the initial hearing.

## COUNSEL

The state fears that assistance of counsel will make institutionalization proceedings adversarial adding to the delay in treatment of the child and increasing the danger of trauma already inflicted by notice and a hearing. Yet the spectre of this particular trauma pales beside the spectre of the trauma inflicted on a child erroneously committed.[20] Notice and the opportunity to be heard may be of little value without the assistance of counsel. *Argesinger v. Hamlin,* 407 U.S. 25, 31 (1972); *Powell v. Alabama,* 287 U.S. 45, 68-69 (1932). A child whose liberty is in question "needs the assistance of counsel to cope with problems of law, to make skilled inquiry into the facts, to insist upon regularity of the proceedings, and to ascertain whether he has a defense and to prepare and submit it." *Gault,* at 36. As the right to counsel applies to

[20] The possibility and danger of error is discussed by D. L. Rosenhan in "On Being Sane in Insane Places," 179 Science 250 (1973). The article describes an experiment in which eight sane persons gained admission to twelve different hospitals and behaved normally. Their sanity was never discovered. Not only was their sanity not detected, but the psychodiagnostic label placed on the individual patients was never removed. According to Professor Rosenhan this error apparently resulted from what statisticians call type two error—error resulting from a Doctor's inclination to call a healthy person sick rather than a sick person healthy because it is more dangerous to misdiagnose illness than health.

Rosenhan suggests that the initial labelings color others' perception of the patient and eventually the patient himself accepts the diagnosis, with all of its connotations and expectations, and behaves accordingly. He also notes that there is substantial evidence that attitudes towards the mentally ill are characterized by fear, hostility, aloofness, and dread.



criminal cases, so it must apply during all significant stages of the commitment process, and plaintiffs must be informed of both their right to counsel and if indigent their right to appointment of free counsel. See, *In re Gault,* at 41; *Heryford v. Parker,* at 397; *Dixon v. Attorney General,* at 966; *Lessard v. Schmidt,* at 1097; *Lynch v. Baxley,* at 389; *United States v. Wade,* 388 U.S. 218, 226-27 (1967); *In re Barnard,* 455 F.2d 1370, 1375-76 (D.C. Cir. 1971); *Sarzan v. Gaughan,* 489 F.2d 1076, 1083-84 (1 Cir. 1973).

## PRESENCE OF PERSON

In *Specht v. United States,* 386 U.S. 605, 610 (1967), the Supreme Court held that commitment proceedings under the Colorado Sex Offenders Act, whether denominated civil or criminal, are subject to the Due Process Clause of the Fourteenth Amendment and that due process requires that the person to be committed "be present with counsel, have an opportunity to be heard, be confronted with witnesses against him, have the right to cross-examine, and to offer evidence of his own." Also see, *Lynch v. Baxley,* at 394. In *Illinois v. Allen,* 397 U.S. 337, 342 (1969) the Court, rejecting the argument that the right to be present is absolute, held that the right of personally confronting witnesses may be lost by consent or at times even misconduct. Expanding this holding the *Lynch v. Baxley* court held that the right to be present may be knowingly and intelligently waived by persons faced with involuntary commitment or by adversary counsel acting in their behalf. This procedure protects such persons' constitutional right to be present and to assist in protecting their interests, yet it recognizes that situations exist where the

absence of such persons from commitment proceedings may serve their own best interests.

We adopt the *Lynch v. Baxley* procedure as appropriate for plaintiffs. Accordingly, we find that a child has a constitutional right to be present at all hearings concerning his proposed commitment. See, *McKiever v. Pennsylvania,* 403 U.S. 528, 543 (1971). This right may be waived by the child, however, and the unbiased tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them. This right may also be waived by the child's attorney, and the unbiased tribunal may accept the waiver upon a finding that the child is too ill to attend the proceedings. See, *Lynch v. Baxley,* at 394.

## RIGHT TO JURY TRIAL

The Supreme Court in *McKiever v. Pennsylvania, supra,* noting that conscientious judges are able fact finders, held that while fundamental fairness requires notice, the rights to counsel, confrontation, and cross-examination, and notice of standard of proof, it does not require jury trials. We agree.

## STANDARD OF PROOF

That the fact finder may commit error is a risk of any litigation. *Speiser v. Randall,* 357 U.S. 513, 525-26 (1958). The standard of proof affects this risk for it instructs the fact finder on the degree of confidence society expects him to have in the correctness of his findings. See



Mr. Justice Harlan concurring in *In re Winship,* 397 U.S. 358, 370-71 (1969). In *Winship,* Justice Harlan suggests that setting the standard of proof for a particular category of adjudication reflects an assessment of the comparative social costs of erroneous factual determinations. He views the decision to apply a preponderance standard to suits between private parties for money damages as a decision that an erroneous verdict is no more serious for one party than for the other. He finds the standard of proof beyond a reasonable doubt required in the institutionalization of a child for delinquency because the social disutility of committing an innocent child—subjecting him to a complete loss of his personal liberty—outweighs the social disutility of committing error in his favor.[21]

[21] Mr. Justice Harlan recognizes that in a judicial proceeding in which there is a dispute about the facts, all the fact finder can acquire is a belief of what probably happened. Mr. Justice White in *Goss v. Lopez,* 419 U.S. 565, 580 (1975) also recognized the possibilities of error when he noted that:

> Disciplinarians, although proceeding in utmost good faith, frequently act on the reports and advice of others; and the controlling facts and the nature of the conduct under challenge are often disputed. The risk of error is not at all trivial, and it should be guarded against if that may be done without prohibitive cost or interference with the educational process.

In discussing the possibilities of erroneous psychiatric diagnoses Rosenhan, in "On Being Sane in Insane Places," *supra,* raises several poignant questions which illustrate some of the problems in this area including:

> How many people, one wonders, are sane but not recognized as such in our psychiatric institutions? How many have been needlessly stripped of their privileges of citizenship, from the right to vote and drive to that of handling their own accounts? How many have feigned insanity in order to avoid the criminal consequences of their behavior, and, conversely,

Following this analysis, balancing the impact of an erroneous decision to commit a person with an erroneous decision to release a person, and taking into consideration the nature of the proceedings, the *Lynch v. Baxley* court held:

> Because the stigmatization and loss of liberty attendant upon forced confinement are of the most profound consequence to the individual affected, due process demands that he be subjected to such disabilities only if the necessity for his commitment is proved by evidence having the highest degree of certitude reasonably attainable in view of the nature of the matter at issue. In a civil commitment proceeding, the questions involved are the primarily subjective ones of the subject's mental condition and the likelihood that he will be dangerous in the future. Such subjective determinations cannot ordinarily be made with the same degree of certainty that might be achieved where purely objective facts and occurrences are at issue. Consequently, the trier of fact must be persuaded by clear, unequivocal, and convincing evidence that the subject of the hearing is in need of

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how many would rather stand trial than live indeterminably in a psychiatric hospital—but are wrongly thought to be mentally ill? How many have been stigmatized by well-intentioned but nevertheless erroneous diagnoses? On the last point recall again that a "type 2 error" in psychiatric diagnosis does not have the same consequences it does in medical diagnosis. A diagnosis of cancer that has been found to be in error is cause for celebration. But psychiatric diagnoses are rarely found to be in error. The label sticks, a mark of inadequacy forever.

These problems are similar to the problems discussed by Mr. Justice Harlan in *Winship* and Mr. Justice White in *Goss v. Lopez*.



> confinement under the minimum standards for commitment herein enumerated.

We agree with this holding and find that the fact finder, in a hearing on commitment of a child, must apply the standard of clear and convincing proof as opposed to the standards of beyond a reasonable doubt and preponderance of the evidence. Applying a preponderance standard creates too great a risk of erroneous commitment, wrongfully depriving a child of his interest in liberty, and interest of "transcending value,"[22] and, given the subjectivity and "relatively undeveloped state of psychiatry as a predictive science,"[23] requiring proof beyond a reasonable doubt creates too great a risk of erroneously releasing children in need of institutionalization.

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## RIGHTS AT THE COMMITMENT HEARING

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Due process requires that before a decision to commit, an adult be given the opportunity to confront and to cross-examine witnesses against him, *Specht v. Patterson*, 386 U.S. at 610; *Lynch v. Baxley* at 394, offer evidence in his own behalf, *Specht v. Patterson* at 610, and offer testimony of witnesses, *Lynch v. Baxley* at 394, citing *White v. Texas*, 388 U.S. 14, 19 (1967).[24] While formalizing commitment procedures, these rights do not require the

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[22] *Speiser v. Randall*, 357 U.S. 513, 525 (1958).

[23] Note, Developments in the Law, Civil Commitment of the Mentally Ill, 87 Harv. L. Rev. 1190, 1302 (1974).

[24] In *Morrissey v. Brewer, supra*, the Supreme Court held that due process requires certain minimum procedures before parole can finally be revoked. These procedures include the opportunity to be heard in person and to present witnesses and documentary

state to abandon the substantive benefits it presently hopes to achieve through treatment and rehabilitation. We commend the steps the state has taken in the interest of the mental health of children in need of institutionalization but, because of the tremendous personal as well as societal loss error might cause, we find that in addition to the rights previously discussed, the rights to confront and to cross-examine witnesses against him, to offer evidence in his own behalf and to offer testimony of witnesses are required before a decision to commit a child is made.[25]

To summarize, then, we have found that before they may be institutionalized plaintiffs and others of their class are entitled to (1) a probable cause hearing within seventy-two (72) hours from the date of their initial detention; (2) a post-commitment hearing within two (2) weeks

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evidence, and the right to confront and cross-examine adverse witnesses (unless the hearing officer specifically finds good cause for not allowing confrontation). Noting that these procedures are essential in criminal trials, where a person may be subjected to the most serious deprivation, and cases where a person may lose his job in society, the Supreme Court in *Wolff, supra,* held that because of the unique problems of penal institutions the determination of whether prisoners are entitled to these rights is best left to the discretion of the officials of the prisons.

[25] In support of their position plaintiffs submitted memoranda of law outlining the substantial procedural safeguards which they contend they are being denied. They briefly mention the contention that plaintiffs should have the right to remain silent. Against this claim we must balance the practical problems plaintiffs' silence may have on psychiatric evaluation almost always needed before plaintiffs may be institutionalized. In view of these potential problems and the limited discussion of the issue in this case we think that it would be inappropriate to decide this issue at this time.



from the date of their initial detention; (3) written notice, including the date, time, and place of the hearing, and a statement of the grounds for the proposed commitment; (4) counsel at all significant stages of the commitment process and if indigent the right to appointment of free counsel; (5) be present at all hearings concerning their proposed commitment; (6) a finding by clear and convincing proof that they are in need of institutionalization; (7) the rights to confront and to cross-examine witnesses against them, to offer evidence in their own behalf, and to offer testimony of witnesses.[26] Accordingly, we declare the pertinent portions of Sections 402 and 403 unconstitutional on their face and as they apply to plaintiffs and others of their class, and we enjoin the enforcement of such portions.[27]

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[26] We neither intend nor expect that all of these procedures will be required every time an attempt to institutionalize a child is made. As we found with respect to the right of the child to be present at all hearings concerning his proposed commitment, we find that, excepting the right to notice and counsel, any or all of these rights may be waived by the child and the unbiased tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them. Because there may be situations where the child either does not understand his rights or is not competent to waive them, any or all of these rights may also be waived by the child's attorney and the unbiased tribunal may accept the waiver upon a finding that the waiver is appropriate.

[27] Some courts have approached claims by children of constitutional deprivation by comparing the rights afforded adults with the rights afforded children and questioning whether there is a peculiar state interest justifying any disparity between them. See *State v. Koome,* 530 P.2d 260 (Wash. 1975). Authority for such an approach can be gleaned from the Supreme Court's statement in *In re Gault,* at 29, that "So wide a gulf between the State's

The foregoing is deemed to constitute findings of fact and conclusions of law as required by F.R. Civ. P. 52 (a).

(s) John J. Gibbons,
John J. Gibbons, *C. J.*

(s) Daniel H. Huyett, 3rd,
Daniel H. Huyett, 3rd, *D. J.*

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treatment of the adult and of the child requires a bridge sturdier than mere verbiage, and reasons more persuasive than cliche can provide." Since we dispose of this case under the Due Process Clause we have no occasion to address the equal protection arguments directed at the disparate treatment of children and adults.

Plaintiffs also claim they are being denied equal protection of the law since persons above the age of eighteen (18) may voluntarily admit or commit themselves to mental institutions and persons eighteen (18) years of age or younger may not. Plaintiffs, however, failed to allege that any of the named plaintiffs ever attempted voluntarily to admit or commit themselves or even that they wish to. Accordingly, we find that plaintiffs lack standing to present this claim.



IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

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Civil Action No. 72-2272

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Kevin Bartley, et al.

vs.

Jack B. Kremens, individually and as Hospital Director of Haverford State Hospital, et al.

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ORDER

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NOW, July 24, 1975, IT IS ORDERED that judgment is entered in favor of plaintiffs and against defendants. Counsel for the parties shall confer and submit an appropriate form of Order consistent with this Opinion within twenty (20) days.

(s) John J. Gibbons,
John J. Gibbons, *C. J.*

(s) Daniel H. Huyett, 3rd,
Daniel H. Huyett, 3rd, *D. J.*

Re: Kevin Bartley, et al. v. Jack B. Kremens, et al. Civil Action No. 72-2272

BRODERICK, D.J., *dissenting.*

It appears to me that the majority opinion has prescribed "an overdose" of due process which could prove fatal to the voluntary commitment of children for in-patient treatment for mental or emotional disorders. The majority opinion declares unconstitutional §§402 and 403 of the Pennsylvania Mental Health and Mental Retardation Act which provides that parents may make application for voluntary admission and commitment of their child age 18 or younger to a facility for examination, treatment and care. The due process procedure prescribed by the majority opinion for all voluntary admissions and commitments of juveniles 18 years of age and younger is as follows: (1) a probable cause hearing within 72 hours from the time of their initial detention; (2) a post- commitment hearing within 2 weeks of their initial detention; (3) written notice to the child stating the time and place of the hearing and the grounds for the proposed commitment. The notice must also be sent to the child's attorney; (4) counsel at all significant stages of the commitment process and, if indigent, the right to the appointment of free counsel; (5) the right of the child to be present at all hearings concerning his proposed commitment; (6) a finding, by "clear and convincing proof", that the child is in need of institutionalization; and (7) the right to confront and to cross-examine witnesses, and to offer evidence on his own behalf.

The Pennsylvania Mental Health and Mental Retardation Act and the regulations promulgated thereunder



provide for the voluntary admission[1] or commitment[2] of persons eighteen years of age or younger by a parent, guardian or individual standing in loco parentis to the person to be admitted. It is this voluntary admission or commitment procedure which the majority has declared unconstitutional. In effect, the majority has declared that no voluntary commitment of children by their parents can meet the constitutional requirements of the Fourteenth Amendment.

Under the Pennsylvania Act and regulations, application for voluntary admission or commitment[3] to a facility may be made by a parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years or younger.[4] In order to be admitted or committed to an institution, any person aged 18 and younger must first be referred from a recognized medical facility. Mental Health/Mental Retardation therapist or Mental Health Agency. Such referral must be accomplished by a psychiatric evaluation and a report which states with specificity the reasons that the child requires institutional care. After such referral, the director of the facility to which the parents seek to have their child ad-

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[1] 50 P.S. §4402(a)(2).

[2] 50 P.S. §4403(a)(2).

[3] The legislature chose to pass two distinct statutes, one of which deals with voluntary admissions to a facility while the other is concerned with voluntary commitments. Apparently, the main distinction in the two statutes is that under the later section dealing with voluntary commitments, the initial commitment is for a period not to exceed thirty days, with successive periods not to exceed thirty days each, so long as care or observation is necessary. The section providing for voluntary admissions contains no corresponding time limitation following admission to a facility.

[4] 50 P.S. §4402(a)(2); 50 P.S. §4403(a)(2).

mitted must then conduct an independent examination of the child in order to determine whether the child is in need of institutional care or observation. If the director's independent examination disagrees with the referring professional's opinion, the child cannot be institutionalized. In the case of a voluntary commitment under §403 of the Act, an acceptance for commitment may not exceed thirty days without a successive application for continued voluntary commitment for an additional thirty day period.[6] In the case of juveniles 13 years of age and older, within 24 hours of admission to the institution, the juvenile must be given written notification which he signs and which is to be fully explained to him and which states that he will be furnished with counsel to represent him. Should a juvenile who is 13 years of age or older object, either orally or in writing, to remaining in the institution, the director, if he feels it is necessary for the youth to remain, may continue the institutionalization for two business days, during which time notification shall be made to the applicant and the referral unit so that either party may institute a §406 proceeding, which is the statutorily required court hearing for an involuntary commitment. During that same two day period, the director must obtain counsel to represent the juvenile. The juvenile's counsel is then furnished with the evaluation of the juvenile by the referral unit, a psychiatric evaluation from the institution, and a written report of the reasons that the institution feels that institutionalization is required.[7]

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[5] 50 P.S. §4402(b); 50 P.S. §4403(b). [No corresponding text citation.]

[6] 50 P.S. §4403(b).

[7] I agree with the majority that these regulations which provide for instituting a §406 hearing do not provide for a period within which such a hearing shall be held following the objection of the child to remaining in the institution.



The effect of the Act and the regulations promulgated thereunder is that two independent medical opinions must concur in a recommendation of institutionalization before a minor can be voluntarily admitted. In the case of juveniles 13 and over, upon their objection to remaining in the institution, future institutionalization must proceed pursuant to the civil court commitment provisions of the Act (Section 406). Section 406 provides the procedure for an involuntary civil court commitment and requires the filing of a petition with the Court of Common Pleas, pursuant to which the Court issues a warrant requiring the allegedly ill person to be brought to Court for a hearing. Counsel appointed for the juvenile represents him at the hearing before the Court of Common Pleas. After the hearing, the Court may order an examination by two physicians or order commitment for a period not to exceed ten days for an examination, after which commitment may be ordered by the Court. Plaintiffs do not attack the constitutionality of the civil court commitments under §406 of the Act which follow the above outlined procedure.

I do not take the position that children have no rights. I simply feel that the procedures outlined by the Pennsylvania Legislature, when balanced against the traditional rights of parents to control the rearing of their children, afford sufficient protection to the child. The present Act does not permit a parent who seeks to admit a child under §402 or §403 to simply hand over the child to the institution. Two psychiatrists must agree, after an examination, that the child is in need of institutionalization. In the case of a voluntary commitment, a periodic review

must be performed by the director every thirty days to determine whether continued institutionalization is necessary. And in the case of a juvenile thirteen years of age and older, the juvenile is entitled to a hearing with counsel concerning his need for institutionalization following his objection. The majority in this case holds that all children are constitutionally entitled to a similar type of hearing within two weeks of their institutionalization. The only group for which the present regulations have not provided a hearing subsequent to their being received in the institution are those children 12 years of age and under. Because of this alleged defect, the majority declares §402 and §403 unconstitutional.

It is now a well settled principle that "due process 'is an elusive concept', the content of which 'varies according to specific factual contexts.'" *Hannah v. Larche,* 363 U.S. 420, 442 (1960); *Logan v. Arafeh,* 346 F. Supp. 1265, 1268 (D. Conn. 1972).

> [C]onsideration for which procedures due process may require under any given set of circumstances must begin with a determination of the precise nature of the government function involved as well as the private interest that has been affected by government action. *Cafeteria and Restaurant Workers Union, Local 473, AFL-CIO v. McElroy,* 367 U.S. 886, 895 (1961).

Due process of law does not require a hearing in every conceivable case of government impairment of private interest. *Stanley v. Illinois,* 405 U.S. 695 (1972).

An evaluation of the competing interest involved in this case leads me to the conclusion that §402 and §403 of the Act and the regulations thereunder are constitutional



on their face. Without minimizing the interest of a child 12 years and under to be free from a wrongful and unwarranted deprivation of his liberty, the traditional interest of the state in preserving the family unit and in maintaining parental control over their young children is such that the strict procedural due process requirements imposed by the majority holding as to "voluntary" commitments are not required by the Fourteenth Amendment.

The Supreme Court has repeatedly recognized and afforded great weight to the rights of parental control and custody of their children and has given due respect to the powerful role of the familial relationship in our democratic society. This substantial interest of parents undeniably warrants deference and, absent a powerful countervailing interest, warrants protection. It is plain that the interest of family integrity and the interests of parents in the care, custody and nurture of their children come to the court with a momentum deserving of respect. *Kovacs v. Cooper,* 336 U.S. 77, 95 (1949) (Frankfurter, J., concurring).

As the Supreme Court stated in *Stanley v. Illinois,* 405 U.S. 645, 651 (1972):

> The Court has frequently emphasized the importance of the family. The rights to conceive and to raise one's children have been deemed "essential," Meyer v. Nebraska, 262 U.S. 390, 399, 43 S.Ct. 625, 626, 67 L.Ed. 1042 (1923), "basic civil rights of man," Skinner v. Oklahoma, 316 U.S. 535, 541, 62 S.Ct. 1110, 1113, 86 L.Ed. 1655 (1942), and "[r]ights far more previous . . . than property rights," May v. Anderson, 345 U.S. 528, 533, 73 S.Ct. 840, 843, 97 L.Ed. 1221 (1953). "It is cardinal with

> us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder." Prince v. Massachusetts, 321 U.S. 158, 166, 64 S.Ct. 438, 442, 88 L.Ed. 645 (1944). The integrity of the family unit has found protection in the Due Process Clause of the Fourteenth Amendment, Meyer v. Nebraska, *supra,* 262 U.S. at 399, 43 S.Ct. at 626, the Equal Protection Clause of the Fourteenth Amendment, Skinner v. Oklahoma, *supra,* 316 U.S., at 541, 62 S.Ct. at 1113, and the Ninth Amendment, Griswold v. Connecticut, 381 U.S. 479, 496, 85 S.Ct. 1678, 14 L.Ed. 2d 510 (1965) (Goldberg, J., concurring).

The authorities cited above make it clear that the parents' interest in directing the upbringing of their children is cognizable and substantial. *Stanley, supra* at 652. Those who nurture the child and direct his destiny have the right coupled with the high duty, to recognize and prepare him for additional obligations. *Pierce v. Society of the Sisters of the Holy Names, etc.,* 268 U.S. 510, 535 (1925). The parents' claim to authority in their own household to direct the rearing of their children has been termed "basic to the structure of our society." *Ginsberg v. State of New York,* 390 U.S. 629, 639 (1968). In *Wisconsin v. Yoder,* 406 U.S. 205 (1972), the Supreme Court stated at 232:

> The history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children. This primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition.



As Chief Judge Bazelon of the District of Columbia Court of Appeals has stated:

> [T]he family is the most effective child-developing agent around, when it wants to be and can be. Out of the plethora of studies of day care and early intervention, one thing stands out: a child needs most a family—it is there that he finds his roots and his education. Mothers and fathers who spend time with their child are better at it than are most organized group care arrangements. David L. Bazelon, *Whose Needy Children?* University of Michigan Journal of Law Reform, vol. 8, 247.

Simply stated, it is my opinion that the present Act and the regulations thereunder which require two independent psychiatric evaluations recommending institutionalization before a parent can voluntarily have his child admitted for treatment or observation provides sufficient protection to the child against an unwarranted or unjustified institutionalization.

The record in this case demonstrates that most parents act in the best interests of their child when making the decision to voluntarily submit their child to institutional treatment. Indeed, those parents whose motives the majority opinion questions are few and far between. Children of the age of twelve and younger are at a stage of development when parents must have direct control over their care and treatment. Parents of such young children are best able to make a determination as to their child's needs, and their decision to seek institutional care and treatment for their child comes only after all other alternatives for treatment and care have been exhausted. To protect a child from being institutionalized when not in need

of such care, the State has developed a system whereby the independent judgment of two experts, trained in this difficult area, must concur with the parents' decision.[8]

As the record in this case clearly reveals, the modern trend in the treatment of the mentally and emotionally ill and the retarded is to institutionalize for the least amount of time and only when all else has failed. The majority opinion expressed concern as to the warehousing of children which might result from the voluntary commitment procedure. However, since the recent opinion of the Supreme Court in *O'Conner v. Donaldson,* 43 U.S.L.W. 4929 (1975), this fear should be dissipated by the Court's holding that a state cannot constitutionally confine a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends. I find that the procedures set forth by the majority which require two hearings with counsel appointed for the child, the confrontation and cross-examination of parents and the requirement of clear and convincing proof of the need of institutional care needlessly destroys the voluntary commitment procedure without affording any significant protection for the child. The adversary nature of the procedure which the majority requires will significantly increase the trauma which accompanies the institutionalization of sick children and will further serve to stigmatize the recipient of the court endorsed commitment. In my opinion, it retards society's progress of recent years in encouraging parents to seek treatment and care of a child in need of hospitalization for a mental or emotional disorder. It will likewise retard society's progress toward removing the stigma still associated by some with psychiatric care. The majority opinion discusses "the stigma associated with civil commitment", yet sets up a system which makes civil commitment necessary. For years now, responsible leaders have been counseling the public that treatment for mental and emotional disorders should be as readily available and as readily acceptable as hospitalization for a tonsillectomy or appendectomy. It certainly will not encourage parents to seek hospitalization for a mentally or emotionally disturbed child when the parent learns that counsel will be appointed for the child and that there will be an adversary hearing at which parents will be subjected to cross-examination as to their motives for seeking hospitalization.

[8] I am aware that courts in Nebraska and Tennessee have declared unconstitutional statutes which permit the voluntary institutionalization of children. *Horacek, etc. v. Exon, et al.*, Civil Action No. 74-L-299 (D.C. Neb. 1974). *Saville v. Treadway,* Civil Action No. 6969 (M.D. Tenn. 1974). However, it is not apparent from reading the opinions in those cases whether both Nebraska and Tennessee provide a protective procedure similar to those provided for under the Pennsylvania statute and regulations.

COURT'S PROPOSED ORDER—SEPTEMBER 16, 1975

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IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

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Civil Action No. 72-2272

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Kevin Bartley, et al.

vs.

Jack B. Kremens, Individually and as Hospital Director of Haverford State Hospital, et al.

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ORDER

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Before Honorable John J. Gibbons, Circuit Judge, and Honorable Daniel H. Huyett, 3rd, and Honorable Raymond J. Broderick, District Judges

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HUYETT, J. September , 1975

On July 24, 1975, we filed our opinion and order in this action granting judgment in favor of plaintiffs and against defendants. Pursuant to Fed. R. Civ. P. 58 and 65 (d), we now enter the following Order to provide and implement the declaratory and injunctive relief to which we held plaintiffs entitled in our opinion.



CLASS ACTION

1. This action is properly maintained as a class action under Fed. R. Civ. P. 23 (b) (2). The class represented by the named plaintiffs includes all children eighteen years of age or younger who have been, are, or may be admitted or committed to mental health facilities in Pennsylvania under the Pennsylvania Mental Health and Mental Retardation Act of 1966. 50 P.S. §§4402 and 4403 (§§402 and 403).

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DECLARATORY JUDGMENT

2. Section 402 (a) (2), section 402 (c), except for the language "any person voluntarily admitted shall be free to withdraw at any time," and section 403 (a) (2) of the Pennsylvania Mental Health and Mental Retardation Act (Act) are declared to be unconstitutional on their face and as applied under the due process clause of the Fourteenth Amendment to the United States Constitution.

*Notice*

3. These sections of the Act are declared invalid in that they fail to require that children eighteen years of age or younger receive prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the child's attorney must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the legislature establishes some other procedure consonant with our opinion and order, it is declared that this notice must be sent not only to the child but also the Clerk of the Court with jurisdiction to be forwarded to the child's attorney.

*Counsel*

4. These sections of the Act are declared invalid in that they fail to require during all significant stages of the commitment process counsel for children eighteen years of age or younger and, if the child is indigent, appointment of free counsel.

*Presence of Child*

5. These sections of the Act are declared invalid in that they fail to afford to children eighteen years of age or younger subject to commitment hearings the rights to presence with counsel, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and the opportunity to offer the testimony of witnesses and other evidence on their own behalf.

*Standard of Proof*

6. These sections of the Act are declared invalid in that they fail to require that the fact finder in a full hearing on the commitment of a child eighteen years of age or younger find by clear and convincing proof that the child is in need of institutionalization.

*Probable Cause Hearing*

7. These sections of the Act are declared invalid in that they permit detention of children eighteen years of age or younger for more than seventy-two (72) hours without a hearing to test whether there is probable cause to believe institutionalization is necessary. These sections of the Act are further declared invalid in that they fail to provide at a probable cause hearing the rights delineated in paragraphs 3 through 5 above.

*Full Commitment Hearing*

8. These sections of the Act are declared invalid in that in the event the initial hearing determines the existence of probable cause, they fail to afford to children eighteen years of age or younger a full hearing on the need for commitment within two weeks from the date of initial detention. These sections of the Act are further declared invalid in that they fail to provide at a full commitment hearing the rights delineated in paragraphs 3 through 6 above.



*Regulations*

9. The regulations promulgated by defendant Wohlgemuth to supplement these sections of the Act, published at 3 Pa. Bull. 1840, are declared invalid and in violation of the due process clause of the Fourteenth Amendment to the United States Constitution in that they fail to require for all children eighteen years of age or younger the rights delineated in paragraphs 3 through 8 above.

*Admissions and Commitments of Plaintiffs*

10. It is declared that all children eighteen years of age or younger admitted or committed to mental health facilities in Pennsylvania under these sections of the Act are unconstitutionally held and detained.

*Use of State Courts*

11. Until the legislature establishes in accord with our opinion and orders an alternate neutral tribunal to conduct the probable cause and full commitment hearings, it is declared that the present facilities of the Commonwealth court system be used for these hearings.

*Application for Treatment of Juveniles*

12. It is declared that a parent, guardian, or person standing in loco parentis may initiate the temporary detention of a child eighteen years of age or younger in a mental health facility if the procedures and requirements of our opinion and order are fully complied with.

*Requirements for Commitment*

13. It is declared that all children eighteen years of age or younger who have been, are, or may be subject to admission or commission to a mental health facility in Pennsylvania are entitled to:

*Notice*

A. Prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the child's attorney must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the legislature establishes some other procedure consonant with our opinion and order, this notice must be sent not only to the child but also to the Clerk of the Court with jurisdiction to be forwarded to the child's attorney.

*Counsel*

B. Counsel during all significant stages of the commitment process and, if the child is indigent, appointment of free counsel.

*Presence of Child and Other Hearing Rights*

C. Presence of the child at all commitment hearings, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the child's behalf.

*Standard of Proof*

D. A finding by clear and convincing proof at the full commitment hearing that the child is in need of institutionalization.



*Probable Cause Hearing*

E. A hearing within seventy-two (72) hours from the date of the initial detention to test whether or not there is probable cause to believe that institutionalization is necessary.

*Full Commitment Hearing*

F. A full commitment hearing within two (2) weeks from the date of the initial detention.

*Waiver*

14. Excepting the rights to notice and counsel, any or all of the rights delineated in paragraph 13 may be waived by the child, and the neutral tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them. Because there may be situations where the child either does not understand his rights or is not competent to waive them, any or all of these rights, excepting notice and counsel, may also be waived by the child's attorney, and the neutral tribunal may accept the waiver upon a finding that the waiver is appropriate.

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INJUNCTIVE RELIEF

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15. It is ordered that the operation of section 402(a)(2), section 402(c), except for the language "any person voluntarily admitted shall be free to withdraw at any time," and section 403(a)(2) of the Pennsylvania Mental Health and Mental Retardation Act (Act) is enjoined in that these sections of the Act are unconstitutional on their face and as applied under the due process

clause of the Fourteenth Amendment to the United States Constitution. It is further ordered that the defendants and their officers, agents, servants, employees, successors, and those persons in active concert or participation with them are enjoined:

*Procedures*

A. To refrain from accepting or continuing the admission or commitment of any child eighteen years of age or younger under the Act to any mental health facility unless the child is or has been provided:

(1) Prior written notice of the date, time and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the child's attorney must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the legislature established some other procedure consonant with our opinion and order, this notice must be sent not only to the child but also to the Clerk of the Court with jurisdiction to be forwarded to the child's attorney.

(2) Counsel during all significant stages of the commitment process and, if the child is indigent, appointment of free counsel.

(3) Presence of the child at all commitment hearings, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the child's behalf.

(4) A finding by clear and convincing proof at the full commitment hearing that the child is in need of institutionalization.



(5) A hearing within seventy-two (72) hours from the date of the initial detention to test whether or not there is probable cause to believe that institutionalization is necessary.

(6) A full commitment hearing within two (2) weeks from the date of the initial detention.

Excepting the rights to notice and counsel, any or all of the rights delineated in paragraph 15(A) may be waived by the child, and the neutral tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them. Because there may be situations where the child either does not understand his rights or is not competent to waive them, any or all of these rights, excepting notice and counsel, may also be waived by the child's attorney, and the neutral tribunal may accept the waiver upon a finding that the waiver is appropriate.

*Regulations*

B. To promulgate and issue regulations and to publish them, within thirty (30) days as immediately effective, requiring that all mental health facilities in Pennsylvania (*see* 50 P.S. §4102 for the definition of "facility") adhere to the opinion and order in this action.

*Notice of Order*

C. To give notice forthwith to all state school and mental hospital directors and their delegates and all directors of all other mental health facilities in Pennsylvania of the opinion and order in this action. Further, to give notice forthwith to all judges of the Courts of Common Pleas in Pennsylvania of the opinion and order in this action.

*Access for Attorneys*

D. To provide to attorneys access to the grounds and facilities of all mental hospitals and institutions, to their individual clients, and to the institutional and hospital records pertaining to their clients' commitments.

*Procedures for Children Already Admitted or Committed*

E. To initiate procedures, commencing immediately, to assure that all children eighteen years of age or younger already admitted or committed pursuant to §§402 and 403 are either discharged or released or recommitted according to the procedures required by our opinion and order. Such discharge, release, or recommitment shall begin immediately and shall be concluded within one hundred and twenty (120) days of the date of this order. Notation shall be made upon the medical records of such children that their discharge, release, or recommitment was effected pursuant to the opinion and order in this action.

*Reports on Implementation*

F. To report to this Court within sixty (60) days and again within one hundred and fifty (150) days on the steps taken and progress made in the implementation of our opinion and order. The one hundred and fifty-day report shall describe, for each mental health facility, the number of children eighteen years of age or younger released, discharged, or recommitted.

_____

*C. J.*

_____

*D. J.*

_____

*D. J.*



## DEFENDANTS' EXCEPTIONS TO COURT'S PROPOSED ORDER—OCTOBER 17, 1975

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## IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Title omitted in printing]

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## EXCEPTIONS TO PROPOSED ORDER

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The Defendants by their counsel, Barry A. Roth, Assistant Attorney General, hereby take exceptions pursuant to Federal Rule of Civil Procedure 46 to the Proposed Order which was issued in the above-captioned matter on or about the 16th day of September, 1975, and make the following representations:

1. The Opinion in this matter was issued on July 24, 1975. (Exhibit A) (22a).

2. A dissenting opinion in this matter was issued on August 7, 1975. (Exhibit B) (52a).

3. Pursuant to This Honorable Court's instruction, Defendants submitted a proposed form of final order (attached hereto as Exhibit C and made a part hereof) (72a) together with an accompanying letter dated August 21, 1975 (attached hereto as Exhibit D and made a part hereof).

4. Pursuant to This Honorable Court's instruction, Plaintiffs submitted a proposed form of final order (at-

tached hereto as Exhibit E and made a part hereof) (62a) together with an accompanying letter dated August 5, 1975 (attached hereto as Exhibit F and made a part hereof), and in addition, a response letter to Defendants' August 21, 1975 letter (see Exhibit D) (attached hereto as Exhibit G and made a part hereof).

5. This Honorable Court submitted a proposed order to all counsel of record for comment (attached hereto as Exhibit H and made a part hereof) (77a).

6. Defendants hereby propound the following exceptions to This Honorable Court's proposed order (see Exhibit H):

A. Paragraph 3 requires that a child's attorney must receive notice of the probable cause hearing or post-commitment hearing 48 hours prior to that hearing; however, there is no method by which the Commonwealth, and in particular the Pennsylvania Department of Public Welfare can even attempt to assure that an attorney who is not yet appointed or selected will be in receipt of that notice.

B. Paragraph 3 requires that notice be sent to the child and the clerk of courts for forwarding to the child's attorney and that a probable cause hearing be held within 72 hours from the date of the child's detention. However, the proposed order does not establish if the child may be detained in the event the child's attorney is not appointed within the 72-hour period. The Opinion, however, states, "in no event shall detention of the child in the absence of a probable cause hearing exceed seventy-two (72) hours from the date of the initial detention." (Exhibit A, p. 16).



C. Paragraph 3 requires notice to be sent by, we assume, the Department of Public Welfare to the Court who, in turn, sends it to counsel for the child, and this must be accomplished within 24 hours of the child's admission. The Department cannot assure that an unknown attorney will receive notice of the child's admission 48 hours prior to the probable cause hearing and 24 hours after the juvenile was admitted; however, address has not been made, if the conditions above were met, if an attorney can adequately prepare his case within 24 hours before the hearing.

D. Paragraph 3 requires notice of the child's admission/commitment be sent to the clerk of the court with jurisdiction; however, is jurisdiction to be determined by the location of the institution or by the county from which the child came?

E. Paragraph 3 fails to provide notice to the parent, guardian, or juvenile's applicant.

F. No provision has been made for a continuance, either by the juvenile, parent, hospital, or master.

G. Paragraphs 5 through 8 and 13 require legal representation for the juvenile. The Commonwealth does not object to representation of children by attorneys; however, in light of *Edleman v. Jordan*, this proposed order compels the State to expend funds from its treasury to pay for counsel for indigent juveniles without legislative authority and appropriations. Our order suggests that the public defender or an alternative organization like community legal services which have statutory or clear grant respon-

sibility to accept as clients all who fall within economic guidelines, be referred the cases of indigent juveniles. No standards of indigency have been set forth and a serious question arises if the parent must pay for counsel to his child. Otherwise, until the Legislature provides an alternative source of counsel for indigent juveniles involved in these types of proceedings, it would be unlawful for This Court to order the Commonwealth to pay for said attorneys.

H. Paragraph 11 designates the Commonwealth Court system as the judicial system for the probable cause and full commitment hearings. This Court is thus creating a cause of action in a separate judicial system without a present legislative or common law foundation. As of October 2, 1975, in an amended petition of writ of habeas corpus, petitioner seeks to have declared Section 408 of the Mental Health and Mental Retardation Act of 1966 unconstitutional because there is a violation of equal protection according to the procedural requirements set forth in *Bartley. In re Bingaman,* Common Pleas Court of Snyder County, No. 496, 1975. It is unclear and a matter of substantial controversy whether a Federal District Court has the authority under the Constitution of the United States or any act of Congress to exercise such direction and control over the Commonwealth's judicial branch of government and its judicial officers.

I. In paragraph 11 This Honorable Court declares that the present facilities of the Commonwealth Court system be used for these hearings and directs that the Legislature order an alternate neutral tribunal



to conduct probable cause and full commitment hearings (Exhibit H, p. 4). However, This Honorable Court fails to realize that the Legislature may provide for an equally constitutional method other than by using the Commonwealth Court system, such as the use of a masters (which is prevalent in the 406 commitment process).

J. Paragraphs 13 and 15 provide the child with an opportunity to offer testimony of witnesses; however, who bears the expense for professional testimony such as psychiatric or psychological testimony? This requirement compels the State to expend funds from its treasury to pay for services which are in direct violation of *Edleman v. Jordan.*

K. Paragraph 15(E) requires the discharge, release, or recommitment of institutionalized juveniles to be accomplished within 120 days from the date of this order. This Honorable Court is without jurisdiction and without authority to order the release or conditional release of juveniles already in custody at State institutions within the context of this civil rights action. The exclusive method by which such relief may be obtained is habeas corpus. Further, pursuant to 28 U.S.C. §2254(b), exhaustion of state remedies is a prerequisite to federal jurisdiction in habeas corpus proceedings. The presentation of a civil rights claim requires no such exhaustion; however, it is not permissible to pursue a habeas corpus remedy through a civil rights action and thus avoid the necessity of referring to the state judicial system for habeas corpus. *Preiser v. Rodriguez,* 411 U.S. 475 (1973).

L. Paragraph 15(E) requires the discharge, release, or recommitment of all juveniles within 120 days from the date of this order. As previously stated, This Court is without jurisdiction and authority to order the release or conditional release of juveniles already in custody at state institutions within the context of this civil rights action. The exclusive method by which such relief may be obtained is habeas corpus. *Preiser v. Rodriguez*, 411 U.S. 475 (1973). The Department cannot programmatically effectuate the Court's requirement to recommit all institutionalized juveniles within 120 days and will have no choice but to discharge this group which approximates 7,000 juveniles to their parents and guardians. No aftercare is provided. The effect of this requirement will cause great harm to this class, the majority of which are severely retarded. Furthermore, discharge in several instances may not occur because parents may refuse to have their child returned to them and appropriate proceedings before the local court will be needed to effectuate appointment of a guardian ad litem for the child.

M. Paragraph 15(E) requires the discharge, release, or recommitment of all juveniles within 120 days from the date of this order. As previously stated, This Court is without jurisdiction and authority to order the release or conditional release of juveniles already in custody at state institutions within the context of this civil rights action. The exclusive method by which such relief may be obtained is habeas corpus. *Preiser v. Rodriguez*, 411 U.S. 475 (1973). It is recommended that notation of each child's condition be made upon the child's medical



record and forwarded to a guardian ad litem to be appointed by This Honorable Court for the express purpose of seeking a writ of habeas corpus action for each child whom the guardian ad litem feels is inappropriately institutionalized. More than 7,000 juveniles are currently located in State mental hospitals, State schools and hospitals, private licensed facilities, etc., and the majority of these children are severely retarded thereby making them incapable of exercising any judgment regarding their commitment.

N. Paragraph 15(F) requires time limits. It is impossible to implement some or all of the requirements of This Court's proposed order within the time indicated for reporting on implementation. Legislative authority is requisite to most, if not all of the proposed procedures required by paragraph 15 of the proposed order. Since the Legislature convened only for a brief session in September and October, and does not reconvene until after the general election in November, at least 180 days from the issuance of the final order is necessary for the Legislature to authorize implementation of appropriate procedures. The Department of Public Welfare has discussed and sent to Senator Louis Coppersmith copies of the Court's Opinion and our exceptions thereto for introducing legislation.

O. An affidavit by Stanley Meyers, Deputy Secretary for Mental Retardation, setting forth the difficulties of implementing This Court's proposed order is attached as Exhibit I.

P. An affidavit by Dr. James Harris, Deputy Secretary for Mental Health and Medical Services

and Commissioner of Mental Health, sets forth the difficulties of implementing This Court's proposed order and is attached as Exhibit J.

Q. The proposed order erroneously makes no provision allowing for the continuation of the "respite care" program or the intensive training program within the Mental Health/Mental Retardation program of the Commonwealth.

R. The Pennsylvania Court Administrator has informed us that he will be writing to the Court and excepting to the proposed order. He is a necessary party to these proceedings and the Commonwealth subscribes to his objections insofar as they effect the Commonwealth.

S. Paragraph 15(F) requires us to submit reports within 60 days and within 150 days a report of our progress and implementation of the proposed order. It is impossible for the reasons mentioned heretofore to accomplish the structure set forth by This Honorable Court within the time limits. Accordingly, we submit that progress reports be afforded to This Honorable Court every three months until accomplishment of the order occurs, and at that time a full report setting forth the number of children 18 years of age or younger who are committed pursuant to Sections 402 and 403 of the Act.

7. General Exceptions

A. This Court is without jurisdiction and without authority to order the release or conditional release of juveniles already in custody at State institutions within the context of this civil rights action.



The *exclusive method* by which such relief may be obtained is habeas corpus. Further, pursuant to 28 U.S.C. 2254(b), exhaustion of state remedies is a prerequisite to federal jurisdiction in habeas corpus proceedings. The presentation of a civil rights claim requires no such exhaustion; however, it is not permissible to pursue a habeas corpus remedy through a civil rights action and thus avoid the necessity of referring to the state judicial system for habeas corpus. *Preiser v. Rodriguez*, 411 U.S. 475 (1973). Additionally, Plaintiffs never sought release of juveniles in State mental health facilities.

B. This Court's proposed order compels the State to expend funds from its treasury to pay for counsel for indigent juveniles without legislative authority and appropriations. This action is in direct violation of *Edleman v. Jordan*, 415 U.S. 651 (1974).

C. It is unclear and a matter of substantial controversy whether a Federal District Court has the authority under the Constitution of the United States or any act of Congress to exercise such discretion and control over the Commonwealth's judicial branch of government and its judicial officers. Thus, This Court, in essence, has created a cause of action in a separate judicial system without a present legislative or common law foundation. To wit, an amended petition of writ of habeas corpus has been filed in the Common Pleas Court of Snyder County, No. 496, 1975 term, in which petitioner seeks to have declared unconstitutional Section 408 of the Mental Health and Mental Retardation Act of 1966 because there is a violation of equal protection according to the pro-

cedural requirements set forth in *Bartley. In re Bingaman.*

D. While there may have been evils within existing State laws, it is case legend that the protection afforded is a matter for legislative judgment. Consequently, it would be improper to have a permanent order substitute for legislative judgment *Gunn v. University Committee To End the War in Vietnam,* 399 U.S. 383 (1970); *Robinson v. Cahill,* 62 N.J. 473, 520, 521, 303 A.2d 273, 298 (1973); *Federal Power Commission v. National Gas Pipeline Company,* 315 U.S. 575, 599, 601 (1942); *Marbury v. Madison,* 2 L.Ed. 60.

Respectfully submitted,

(s) Barry A. Roth
Barry A. Roth
*Assistant Attorney General*

Paul J. Carey, Jr.
*General Counsel*

Robert P. Kane
*Attorney General*

323 Health and Welfare Building
Harrisburg, Pennsylvania 17120
(717) 787-6398
October 17, 1975



FINAL ORDER—NOVEMBER 17, 1975

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IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

---

Civil Action No. 72-2272

---

Kevin Bartley, et al.

vs.

Jack B. Kremens, Individually and as Hospital Director of Haverford State Hospital, et al.

---

ORDER

---

Before Honorable John J. Gibbons, Circuit Judge, and Honorable Daniel H. Huyett, 3rd, and Honorable Raymond J. Broderick, District Judges

---

HUYETT, J. November 17, 1975:

On July 24, 1975, we filed our opinion and order in this action granting judgment in favor of plaintiffs and against defendants. Pursuant to Fed. R. Civ. P. 58 and 65(d), we now enter the following Order to provide and implement the declaratory and injunctive relief to which we held plaintiffs entitled in our opinion.

## CLASS ACTION

1. This action is properly maintained as a class action under Fed. R. Civ. P. 23(b)(2). The class represented by the named plaintiffs includes all children eighteen years of age or younger who have been, are, or may be admitted or committed to mental health or mental retardation facilities in Pennsylvania under the Pennsylvania Mental Health and Mental Retardation Act of 1966. 50 P.S. §§4402 and 4403 (§§402 and 403).

---

## DECLARATORY JUDGMENT

2. Section 402(a)(2), section 402(c), except for the language "any person voluntarily admitted shall be free to withdraw at any time," and section 403(a)(2) of the Pennsylvania Mental Health and Mental Retardation Act (Act) are declared to be unconstitutional on their face and as applied under the due process clause of the Fourteenth Amendment to the United States Constitution.

*Notice*

3. These sections of the Act are declared invalid in that they fail to require that children eighteen years of age or younger receive prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the child's attorney must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the legislature establishes some other procedure consonant with our opinion and order, it is declared that this notice must be sent not only to the child but also the Clerk of the Court with jurisdiction to be forwarded to the child's attorney.



*Counsel*

4. These sections of the Act are declared invalid in that they fail to require during all significant stages of the commitment process counsel for children eighteen years of age or younger and, if the child is indigent, appointment of free counsel.

*Presence of Child*

5. These sections of the Act are declared invalid in that they fail to afford to children eighteen years of age or younger subject to commitment hearings the rights to presence with counsel, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and the opportunity to offer the testimony of witnesses and other evidence on their own behalf.

*Standard of Proof*

6. These sections of the Act are declared invalid in that they fail to require that the fact finder in a full hearing on the commitment of a child eighteen years of age or younger find by clear and convincing proof that the child is in need of institutionalization.

*Probable Cause Hearing*

7. These sections of the Act are declared invalid in that they permit detention of children eighteen years of age or younger for more than seventy-two (72) hours without a hearing to test whether there is probable cause to believe institutionalization is necessary. These sections of the Act are further declared invalid in that they fail to provide at a probable cause hearing the rights delineated in paragraphs 3 through 5 above.

*Full Commitment Hearing*

8. These sections of the Act are declared invalid in that in the event the initial hearing determines the exis-

tence of probable cause, they fail to afford to children eighteen years of age or younger a full hearing on the need for commitment within two weeks from the date of initial detention. These sections of the Act are further declared invalid in that they fail to provide at a full commitment hearing the rights delineated in paragraphs 3 through 6 above.

*Regulations*

9. The regulations promulgated by defendant Wohlgemuth to supplement these sections of the Act, published at 3 Pa. Bull. 1840, are declared invalid and in violation of the due process clause of the Fourteenth Amendment to the United States Constitution in that they fail to require for all children eighteen years of age or younger the rights delineated in paragraphs 3 through 8 above.

*Admissions and Commitments of Plaintiffs*

10. It is declared that all children eighteen years of age or younger admitted or committed to mental health or mental retardation facilities in Pennsylvania under these sections of the Act are unconstitutionally held and detained.

*Use of State Courts*

11. Until the legislature establishes in accord with our opinion and order an alternate neutral tribunal to conduct the probable cause and full commitment hearings, it is declared that the present facilities of the Commonwealth court system be used for these hearings.

*Application for Treatment of Juveniles*

12. It is declared that a parent, guardian, or person standing in loco parentis may initiate the temporary detention of a child eighteen years of age or younger in a mental health or mental retardation facility if the procedures and requirements of our opinion and order are fully complied with.



*Requirements for Commitment*

13. It is declared that all children eighteen years of age or younger who have been, are, or may be subject to admission or commission to a mental health or mental retardation facility in Pennsylvania are entitled to:

*Notice*

A. Prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the child's attorney must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the legislature establishes some other procedure consonant with our opinion and order, this notice must be sent not only to the child but also to the Clerk of the Court with jurisdiction to be forwarded to the child's attorney.

*Counsel*

B. Counsel during all significant stages of the commitment process and, if the child is indigent, appointment of free counsel.

*Presence of Child and Other Hearing Rights*

C. Presence of the child at all commitment hearings, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the child's behalf.

*Standard of Proof*

D. A finding by clear and convincing proof at the full commitment hearing that the child is in need of institutionalization.

*Probable Cause Hearing*

E. A hearing within seventy-two (72) hours from the date of the initial detention to test whether or not there is probable cause to believe that institutionalization is necessary.

*Full Commitment Hearing*

F. A full commitment hearing within two (2) weeks from the date of the initial detention.

*Waiver*

14. Excepting the rights to notice and counsel, any or all of the rights delineated in paragraph 13 may be waived by the child, and the neutral tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them. Because there may be situations where the child either does not understand his rights or is not competent to waive them, any or all of these rights, excepting notice and counsel, may also be waived by the child's attorney, and the neutral tribunal may accept the waiver upon a finding that the waiver is appropriate.

---

## INJUNCTIVE RELIEF

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15. It is ordered that the operation of section 402 (a) (2), section 402 (c), except for the language "any



person voluntarily admitted shall be free to withdraw at any time," and section 403 (a) (2) of the Pennsylvania Mental Health and Mental Retardation Act (Act) is enjoined in that these sections of the Act are unconstitutional on their face and as applied under the due process clause of the Fourteenth Amendment to the United States Constitution. It is further ordered that the defendants and their officers, agents, servants, employees, successors, and those persons in active concert or participation with them are enjoined:

*Procedures*

A. To refrain from accepting or continuing the admission or commitment of any child eighteen years of age or younger under the Act to any mental health or mental retardation facility unless the child is or has been provided:

(1) Prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the child's attorney must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the legislature establishes some other procedure consonant with our opinion and order, this notice must be sent not only to the child but also to the Clerk of the Court with jurisdiction to be forwarded to the child's attorney.

(2) Counsel during all significant stages of the commitment process and, if the child is indigent, appointment of free counsel.

(3) Presence of the child at all commitment hearings, an opportunity to be heard, confrontation

and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the child's behalf.

(4) A finding by clear and convincing proof at the full commitment hearing that the child is in need of institutionalization.

(5) A hearing within seventy-two (72) hours from the date of the initial detention to test whether or not there is probable cause to believe that institutionalization is necessary.

(6) A full commitment hearing within two (2) weeks from the date of the initial detention.

Excepting the rights to notice and counsel, any or all of the rights delineated in paragraph 15(A) may be waived by the child, and the neutral tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them. Because there may be situations where the child either does not understand his rights or is not competent to waive them, any or all of these rights, excepting notice and counsel, may also be waived by the child's attorney, and the neutral tribunal may accept the waiver upon a finding that the waiver is appropriate.

*Regulations*

B. To promulgate and issue regulations and to publish them, within thirty (30) days as immediately effective, requiring that all mental health and mental retardation facilities in Pennsylvania (*see* 50 P.S. §4102 for the definition of "facility") adhere to the opinion and order in this action.



*Notice of Order*

C. To give notice forthwith to all state school and mental hospital directors and their delegates and all directors of all other mental health and mental retardation facilities in Pennsylvania of the opinion and order in this action. Further, to give notice forthwith to all judges of the Courts of Common Pleas in Pennsylvania of the opinion and order in this action.

*Access for Attorneys*

D. To provide to attorneys access to the grounds and facilities of all mental hospitals and institutions, to their individual clients, and to the institutional and hospital records pertaining to their clients' commitments.

*Procedures for Children Already Admitted or Committed*

E. To initiate procedures, commencing immediately, to assure that all children eighteen years of age or younger already admitted or committed pursuant to §§402 and 403 are either discharged or released or recommitted according to the procedures required by our opinion and order. Such discharge, release, or recommitment shall begin immediately and shall be concluded within one hundred and twenty (120) days of the date of this order, unless an extention is granted by this Court for good cause shown. Notation shall be made upon the medical records of such children that their discharge, release, or recommitment was effected pursuant to the opinion and order in this action. In addition, any person admitted or committed pursuant to §§402 or 403 at a time when he or she was eighteen years of age or younger but who has reached his or her nineteenth birthday shall be brought before a Commonwealth court or alternate neutral tribunal and informed of his or her options under §§402 and 403 for

voluntary withdrawal. Should such person choose to withdraw voluntarily, he or she shall be released immediately unless proper procedures are initiated pursuant to the appropriate Pennsylvania statutes governing the involuntary commitment of adults.

*Reports on Implementation*

F. To report to this Court within sixty (60) days and again within one hundred and fifty (150) days on the steps taken and progress made in the implementation of our opinion and order. The one hundred and fifty-day report shall describe, for each mental health or mental retardation facility, the number of children eighteen years of age or younger released, discharged or recommitted and the number of persons who have reached their nineteenth birthday but who were eighteen years of age or younger at the time they were admitted or committed pursuant to §402 or §403 who have been released, voluntarily admitted or committed, or involuntarily committed.

(s) John J. Gibbons
*C. J.*

(s) Daniel A. Huyett 3rd
*D. J.*

(s) R. J. Broderick
*D. J.*



## NOTICE OF APPEAL

---

## IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

---

Civil Action No. 72-2272

---

Kevin Bartley; Steve Gentile; Lesile Levine; Vicki Mathews; Mark Weand; minors, through their next friend, individually and on behalf of all others similarly situated,
*Plaintiffs*

**v.**

Jack B. Kremens, individually and as Hospital Director of Haverford State Hospital; Helene Wohlgemuth, individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; William B. Beach, Jr., individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,
*Defendants*

---

## NOTICE OF APPEAL TO THE SUPREME COURT OF THE UNITED STATES

---

Notice is hereby given that Jack B. Kremens, et al., the Defendants above-named, hereby appeal to the Supreme Court of the United States from the final order granting a permanent injunction in favor of Plaintiffs and

against Defendants, entered in this action on November 17, 1975.

This appeal is taken pursuant to 28 U.S.C. §1253.

(s) Barry A. Roth
Barry A. Roth
*Assistant Attorney General*
Counsel for Defendants

---

[Caption Omitted]

AFFIDAVIT OF SERVICE

Barry A. Roth certifies that he, by certified mail, return receipt requested, served:

David Ferleger, Esq.
1427 Walnut Street
Philadelphia, Pa. 19102

John Gabroy, Esq.
1710 Spruce Street
Philadelphia, Pa. 19103

Thomas B. Harvey, Jr.
American Civil Liberties Foundation
260 South 15th Street
Philadelphia, Pa. 19102

Jay Stanley Pottinger
Assistant U. S. Attorney General
Department of Justice
Washington, D.C. 20530

Robert C. Burgdorf
National Association for Retarded Citizens
1235 North Eddy Street
South Bend, Indiana 46617



Peter Sandman
Youth Law Center of California
795 Turk Street
San Francisco, California 94102

by sending them a copy of the Notice of Appeal at the above address.

(s) Barry A. Roth
Barry A. Roth
*Assistant Attorney General*

Dated:

Sworn to and subscribed before me on this 24th day of November, 1975.

[Illegible]
*Notary Public*

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1975
No.

[Title omitted in printing.]

*To Mr. Justice Brennan, Circuit Justice:*

APPLICATION FOR A STAY[1]

Appellants, by this application, *inter alia* seek to protect the integrity of the Commonwealth of Pennsylvania's legislative, judicial and executive branches of government as well as the Commonwealth's general fund in keeping with this court's holding in *Edelman v. Jordan*, 415 U.S. 651 (1974). Moreover, the appellants seek to preserve the delicate balance between competing jurisdictions in the traditional area of habeas corpus relief as set forth by this Court in *Preiser v. Rodriguez*, 411 U.S. 475 (1973).

The order of the lower court enjoining the continued use of Pennsylvania's statutes which prescribe the method by which juveniles may be voluntarily committed to mental health facilities in Pennsylvania[2] (See pp. 1, 2 of Exhibit

[1] The Defendants' Motion for a Stay was denied by the lower Court on December 2, 1975 (Motion and Order attached hereto as Exhibit A).

[2] Act of October 20, 1966, special sess. No. 3, P.L. 96, art. IV, §§402, 403, 50 P.S. §§4402, 4403 (1966).



(D)) must be stayed pending review by this Court in order to prevent an irreversible injury to the aforementioned interests of the Commonwealth. In support of this application, the appellants assert:

PROCEEDINGS BELOW

1. This class action was brought under the Civil Rights Act, 42 U.S.C. §1983 and sought both declaratory and injunctive relief against the continued operation of sections 402 and 403 of Pennsylvania's Mental Health and Mental Retardation Act. A three judge court was convened and a majority thereof issued the attached opinion on July 24, 1975 (See Exhibits B and C).[3] And finally, over defendants' strong objections, on November 17, 1975, the final order was issued in this case (Exhibit D).

2. The Defendants took formal exceptions to the lower Courts' order (Exhibit B and F).

REASONS FOR GRANTING THE STAY

3. This action constituted a challenge to the legality of the plaintiffs' confinement in the various mental health and mental retardation facilities throughout the Commonwealth.

4. Pennsylvania law specifically provides that habeas corpus is the remedy to be used in challenging the legality of one's confinement. Section 426 of the Mental Health and Mental Retardation Act of 1966 provides in relevant part:

> "Every person committed or detained in a facility by reason of the provisions of this act or anyone

[3] District Judge Broderick dissented (Exhibit B).

acting on his behalf, may at any time, petition for a writ of habeas corpus and, except as hereinafter provided, said petition shall be filed in accordance with the provisions of the Act of May 25, 1951 (P.L. 415) [note omitted].

(b) Said petition may be based upon the following grounds:

(1) the insufficiency or illegality of the proceeding leading to such person's commitment . . ."

5. Moreover, this Court has held that it is improper for a federal court to entertain a civil rights action which challenges the legality of one's confinement. *Preiser v. Rodriguez*, 411 U.S. 475 (1973). This Court specifically held that in cases such as those described below, the exclusive remedy is habeas corpus and that a civil rights action was not a permissible alternative.

"Thus, whether the petitioner's challenge to his custody is that the statute under which he stands convicted is unconstitutional, as in Ex parte Siebold, supra; that he had been imprisoned prior to trial on account of a defective indictment against him, as in Ex parte Royall, 117 U.S. 241, 6 S.Ct. 734, 29 L.Ed. 868 (1886); that he is unlawfully confined in the wrong institution, as in In re Bonner, 151 U.S. 242, 14 S.Ct. 323, 38 L.Ed. 149 (1894), and Humphrey v. Cady, 405 U.S. 504, 92 S.Ct. 1048, 31 L.Ed.2d 394 (1972); *that he was denied his constitutional rights at trial,* as in Johnson v. Zerbst, supra; that his guilty plea was invalid, as in Von Moltke v. Gillies, 332 U.S. 708, 68 S.Ct. 316, 92 L.Ed. 309 (1948); that he is being unlawfully detained by the Executive or the military, as in Parisi v. Davidson, 405 U.S. 34, 92 S.Ct. 815, 31 L.Ed.2d 17 (1972); or that his parole was unlawfully revoked, causing him to be reincarcerated in prison, as in Morrissey v. Brewer, 408 U.S. 471, 92 S.Ct. 2593, 33 L.Ed.2d 484 (1972)—*in each case his grievance is that he is being unlawfully subjected to physical restraint, and in each case habeas corpus has been accepted as the specific instrument to obtain release from such confinement.* [note omitted]" (Emphasis added.) 411 U.S. at 486.



6. The lower court in this case not only entertained plaintiffs' challenge to the fact of their confinement within the context of a civil rights action, and thus did not require exhaustion of state remedies, but also ordered that all of the thousands of plaintiffs either be released from confinement, or recommitted pursuant to the procedures established by the court within 120 days. (See Exhibit D, pp. 8-9, para. 15E).

7. The rule of *Preiser* applies fully to this case and all of the considerations underlying that decision, including considerations of comity are applicable to this case.

8. Notwithstanding the fact that a new cause of action in the Commonwealth of Pennsylvania was created by the lower court in this case, the Court Administrator's Office which is the official administrative arm of the Commonwealth's judiciary was not formally brought into this action as a party.

9. The Court Administrator was permitted to comment on the order before it was adopted (Exhibit G).

10. The Court Administrator has informed the lower court of its disapproval of the Order in this case to

the extent that a massive additional case load has been immediately placed upon the dockets of the courts of general jurisdiction in the Commonwealth of Pennsylvania.

11. The lower court's action in this case constitutes improper judicial legislation. Moreover, the order in this case is not narrowly drawn to effectuate its decision, but rather presumes to establish an entire system of juvenile admissions to mental health and mental retardation facilities. As such, the order in this case will cause administrative confusion, unduly interfere with the legislative process, and runs contra to the rule of this court in *Graves v. Barnes*, 405 U.S. 1201 (1972). (See Meyers & Harris affidavits, Exhibits I & J).

12. In short, the order of the lower court has required "the impossible" of the Commonwealth's judiciary and executive, and has preempted the legislature from performing its role in this area of needed legislative action (See letter from Court Administrator to Presiding Judge, Exhibit H).

13. In violation of the Eleventh Amendment to the Constitution of the United States and this Court's holding in *Edelman v. Jordan, supra,* the lower court has ordered that the full panoply of due process rights including the rights to a hearing and counsel be provided retroactively to *all* juveniles presently incarcerated in a mental health or mental retardation facility in the Commonwealth of Pennsylvania.

14. As in *Edelman*, the district court here has issued both prospective and retroactive relief, and as in *Edelman* the retroactive relief was structured to conform with the prospective injunctive relief. And again, as in *Edelman*, "the funds to satisfy the award [retroactive relief] in this



case must inevitably come from the general revenues of the [s]tate . . . ," *id.* at 459. Therefore, the rule of *Edelman* requires reversal of at least this aspect of the lower court's holding.

15. The lower court in this case has ordered the Commonwealth to expend funds from its general fund to provide commitment procedures retroactively even though the Commonwealth "was under no court-imposed obligation to conform to a different standard" *Edelman, supra* at 668.

16. The issues in this case are extremely significant *Times-Picayune Publishing Corp. v. Schulingkamp,* 419 U.S. 1301 (1974). In fact there are currently pending many lawsuits in federal courts involving juveniles' due process rights in the mental health area which will inevitably involve issues similar to those raised by this application and appeal, e.g., *Kidd v. Schmidt,* No. 74-C-605 (E.D. Wisc.); *Poe v. Weinberger,* No. 74-1800 (D.D.C.); *Brown v. Allerton,* No. 75-0450 (E.D. Va.); *Goldy v. Beal,* No. 75-791 (M.D. Pa.) thus it is of critical importance in this area that this Court resolve the fundamental jurisdictional and constitutional questions presently being raised.

17. There is a substantial likelihood of reversal of, at the very least, some of the relief ordered by the lower court on the basis of issues raised by this application and appeal, *Graves v. Barnes,* 405 U.S. 1201 (1972).

18. It is clear that should the requested stay be denied the Commonwealth could never be restored to the *status quo ante* see *Edelman v. Jordan,* 414 U.S. 1301, 1302-3 (1973). All of the funds expended in complying

with the retroactive award of relief would of course be totally irretrievable by the Commonwealth in this case, see also *King v. Smith,* 88 S.Ct. 842 (1968).

19. Similarly, the administrative and judicial disruption and confusion that will result from attempts to implement this decree will cause irreparable harm to the Commonwealth should the lower court's order not be stayed pending this appeal. (See Meyers and Harris affidavits as well as Court Administrator's Letter, Exhibits I, J and H).

20. The plaintiffs will suffer no irreparable harm for there is always available to them the full and complete remedy of habeas corpus pursuant to 50 P.S. §4426.

21. If the stay is not granted in this case judicial review of most, if not all, of appellants' contentions will be precluded because those issues will be moot. This court has in the past found considerations of mootness to be appropriate and sufficient in deciding whether or not to grant a stay of an injunction. In *Republican State Central Committee v. Ripon Society,* in 409 U.S. 1222, 1225 (1972) this Court held that:

> "the fact that a stay here, instead of precluding any judicial review . . . preserves these issues for review in a manner conducive to careful study and consideration is itself a reason to stay the injunction."

See also, *Parisi v. Davidson,* 396 U.S. 1233 (1969); *Public Service Board v. United States,* 87 S.Ct. 3 (1966) and *Bandy v. United States,* 82 S.Ct. 11 (1961).

22. The appellants stand ready to file their jurisdictional statement in such time as this court may direct and thus urge that any delay in the implementation of



the relief ordered by the lower court can be minimized by the granting of an expeditious appeal. *National League of Cities v. Brennan,* 419 U.S. 1321 (1974) (stay granted) 419 U.S. 1100 (1974) (Stay continued; time for jurisdictional statement and response shortened); *Smith v. Richey,* 89 S.Ct. 55 (1968) (stay granted with conditions of expedition).

23. Defendants respectfully request that should this request for a stay be denied that such denial be without prejudice. *National Labor Relations Board v. Getman,* 404 U.S. 1204 (1971).

WHEREFORE, the defendants urgently request that this Court stay the order of the lower court in pending full appellate review of the issues presently before the Court.

Respectfully submitted,

(s) Norman J. Watkins
Norman J. Watkins
*Deputy Attorney General*

Barry A. Roth
*Assistant Attorney General*

Robert P. Kane
*Attorney General*

*Of Counsel:* Jeffrey Cooper

Dated: December 8, 1975

WESTERN UNION
TELEGRAM

TO: THE CHIEF JUSTICE AND JUSTICES OF THE SUPREME COURT OF THE UNITED STATES 1 FIRST STREET N.E. WASHINGTON D.C. 20543

RE: KREMENS v. BARTLEY, APPEAL FROM U.S. DISTRICT COURT, E.D. PA. #72-2272—REQUEST FOR STAY

ORDER APPEALED FROM CALLS FOR JUDICIAL INTERVENTION IN ESTIMATED SIX TO EIGHT THOUSAND CASES WITHIN FIVE MONTHS. COURT ADMINISTRATOR OF PENNSYLVANIA PREPARING TO INTERVENE IN THE ACTION, IF POSSIBLE, AND HE AND THIS COURT JOIN WITH THE COMMONWEALTH IN THE REQUEST FOR A STAY. FAILURE OF STAY WILL RESULT IN OVERWHELMING AND DISRUPTING THE JUDICIAL SYSTEMS OF PENNSYLVANIA WHICH ARE ALREADY OVERLOADED WITH REGULAR COURT BUSINESS.

BENJAMIN R. JONES
CHIEF JUSTICE OF PENNSYLVANIA

HON. THURGOOD MARSHALL
HON. HARRY A. BLACKMUN
HON. LEWIS F. POWELL, JR.
HON. WILLIAM H. REHNQUIST

SEND TO: (AT ABOVE ADDRESS)
HON. WARREN E. BURGER
HON. WILLIAM J. BRENNAN, JR.
HON. POTTER STEWART
HON. BYRON R. WHITE



SUPREME COURT OF THE UNITED STATES
OFFICE OF THE CLERK
Washington, D.C. 20543
December 15, 1975

Norman J. Watkins, Esq.
Deputy Attorney General of
Pennsylvania
Department of Justice
Harrisburg, Pennsylvania 17120

RE: Jack B. Kremens, et al. v. Kevin B. Bartley, et al., No. A-527

Dear Mr. Watkins:

The Court today entered the following order in the above-entitled case:

The application for a stay of the judgment of the United States District Court for the Eastern District of Pennsylvania (Civil Action No. 72-2272), presented to Mr. Justice Rehnquist and by him referred to the Court, is granted.

Very truly yours,

Michael Rodak, Jr., *Clerk*
by Francis J. Lorson
Francis J. Lorson
*Deputy Clerk*

cc: David Ferleger, Esquire
1427 Walnut Street
Philadelphia, Pennsylvania 19102

Clerk, USDC for ED Pennsylvania
(No. 72-2272)

Supreme Court, U. S.
FILED
FEB 25 1976
MICHAEL RODAK, JR., CLERK

IN THE

# SUPREME COURT OF THE UNITED STATES

**October Term, 1975**

---

No. 75-1064

---

JACK B. KREMENS, *Individually and as Hospital Director of Haverford State Hospital;* FRANK S. BEAL, *Individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania;* WILLIAM B. BEACH, JR., *Individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania, Appellants*

*v.*

KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND, *Minors, Through Their Next Friend, Individually and on Behalf of All Others Similarly Situated, Appellees*

---

## MOTION TO AFFIRM

---

On Appeal from the Judgment of the United States District Court for the Eastern District of Pennsylvania

---

DAVID FERLEGER
*Counsel for Appellees*
*Mental Patient Civil Liberties Project*
*Public Interest Law Center of Philadelphia*
1315 Walnut Street, Suite 1600
Philadelphia, Pennsylvania 19107

THE LEGAL INTELLIGENCER, 66 NORTH JUNIPER STREET, PHILA., PA. 19107 (215) 561-4850

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IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1975

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No. 75-1064

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JACK B. KREMENS, *Individually and as Hospital Director of Haverford State Hospital*; FRANK S. BEAL, *Individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania*; WILLIAM B. BEACH, JR., *Individvally and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania, Appellants*

*v.*

KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND, *Minors, Through Their Next Friend, Individually and on Behalf of All Others Similarly Situated, Appellees*

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# MOTION TO AFFIRM

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On Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania

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Appellees, pursuant to Rule 16 of the Rules of the Supreme Court of the United States, move that the final judgment and decree of the District Court be affirmed on the grounds that the questions involved are so unsubstantial as not to need further argument, that the decision

below is obviously correct and that there is no conflict of opinion among the courts on the federal questions involved.

## QUESTIONS PRESENTED

1. Was the District Court correct in holding that parents, guardians and persons in *loco parentis* who seek mental commitment of their juvenile wards cannot waive the rights of these juveniles to substantial procedural protections prior to involuntary indeterminate institutionalization?

2. Did the District Court abuse its discretion in requiring the defendant state officials to assure that juveniles, presently committed, receive constitutional state procedures to determine whether they are mentally disabled and in need of institutionalization?

3. Does the District Court's requirement of constitutional state procedures for juveniles, presently committed, violate the Eleventh Amendment to the Constitution of the United States?



## STATEMENT OF THE CASE

Appellees do not defer to the appellants' statement of the case because it is incomplete and fails to describe both the extensive factual basis for the District Court's opinion and order, and the legal grounds upon which the District Court rested its decision.

On November 16, 1972, plaintiffs filed this class action against state officials challenging those portions of Pennsylvania mental health statutes which permit the state to detain persons eighteen years of age or younger in mental institutions without substantial procedural protections including, *inter alia*, notice, counsel and opportunity for hearing. "In essence, plaintiffs claim that the present procedures do not adequately assure against the mistaken commitment of children who are not mentally ill." District Court Opinion, A.J.S.[1] at 25a-26a; 402 F. Supp. at 1042-1043.[2]

A three-judge court was convened pursuant to 28 U.S.C. §§2281, 2284 and, prior to trial, extensive factual stipulations were entered into. At a three day hearing before the three judges, the testimony of six expert psychiatrists was taken and depositions of three additional expert psychiatrists were admitted into evidence.

On July 24, 1975, the District Court issued its opinion, one judge dissenting, and requested the parties to submit proposed implementation orders. (A.J.S. at 51a). The District Court considered these proposals and submitted to the parties for comment a proposed order of its own. After further comment (including a statement by the Court Administrator of Pennsylvania) and modification, a final

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1. Appellants' *Appendix to Jurisdictional Statement* is abbreviated herein "A.J.S." Citations are to page numbers.

2. For convenience, all references to the District Court's reported opinion include the official citation thereof, 402 F. Supp. 1039 (E.D. Pa. 1975), in addition to reference to the *Appendix to Jurisdictional Statement*.

order was adopted unanimously by the three-judge court. (A.J.S. at 97a, *et seq.*)

The Pennsylvania Mental Health and Mental Retardation Act of 1966, 50 P.S. §§4402, 4403, provides that persons eighteen years of age or younger may be institutionalized—without counsel or opportunity for hearing—simply upon application of a "parent, guardian or person in loco parentis."[3] The named plaintiffs were each involuntarily committed under the challenged statutory provisions.

Juveniles are committed to mental institutions in Pennsylvania for a wide variety of behaviors. The District Court found:[4]

> Class members have also been committed to mental hospitals for running away, robbing a gas station, stealing in general, chasing and striking a girl, arson, delinquent behavior in general, truancy, physical ailments such as colitis and weight loss, school phobia, and drug overdose.

(A.J.S. at 29a); 402 F. Supp. at 1044. One retarded person was institutionalized for "rage reactions during which he attacked others" and another for being a "management problem." *Id.*

Conflicts within families were also found to be the basis for institutionalization. For example, Plaintiff L. L., who was 15 years old when committed, came from a troubled family situation; the District Court found:

3. See text of statutes at A.J.S. at 23a-24a, n. 2; 402 F. Supp. at 1041-1042, n. 2. The application must be accepted by the facility. 50 P.S. §4401. After this action was filed, the defendants adopted certain regulations with regard to these statutes. A.J.S. at 25a-26a, n. 5; 402 F. Supp. at 1042-1043, n. 5.

4. These factual findings were based upon "summaries contained in the final pretrial order which have been stipulated to and on" one of appellants' exhibits. A.J.S. at 27a; 402 F. Supp. at 1043. Only selected representative examples of the District Court's extensive and consistent findings will be given here.



> Her difficulties in relating to her mother resulted in her commitment. Hospital records show that she threatened the lives of her mother and sister and that she has a personality disorder. Her parents are divorced and her father is remarried, living in Florida. At the time of her commitment and the time this action was filed, she would have preferred to have been with her father and when she is with him her behavior is excellent.

(A.J.S. at 28a); 402 F. Supp. at 1044. A "poor family situation" where the "mother of the child did not get along well with the child" resulted in the commitment of one retarded person; another was institutionalized "because the child interfered with the routine of the household and disturbed family members." (A.J.S. at 29a); 402 F. Supp. at 1044.

In its detailed and well-reasoned opinion, the District Court determined that "the state is required to provide substantial procedures when there is the possibility of erroneously and wrongfully depriving persons of their liberty by committing them to mental institutions." (A.J.S. at 32a); 402 F. Supp. at 1045 (citations omitted). The stigma and incarceration associated with mental commitments were found to command the observance of due process. Recognizing that "[i]n deciding to institutionalize their children, parents, as well as guardians ad litem or persons standing in loco parentis, may at times be acting against the interest of their children," the District Court held that parents "may not effectively waive personal constitutional rights of their children." (A.J.S. at 36a-37a); 402 F. Supp. at 1047-1048.

Balancing the competing interests of the plaintiffs and the state, the District Court held that, before they may be institutionalized, plaintiffs and their class are entitled to "(1) a probable cause hearing within seventy-two (72) hours from the date of their initial detention; (2) a post-commitment hearing within two (2) weeks from the date of their initial detention; (3) written notice, including the date, time, and place of the hearing, and a statement of the

grounds for the proposed commitment; (4) counsel at all significant stages of the commitment process and if indigent the right to appointment of free counsel; (5) be present at all hearings concerning their proposed commitment; (6) a finding by clear and convincing proof that they are in need of institutionalization; (7) the rights to confront and to cross-examine witnesses against them, to offer evidence in their own behalf, and to offer testimony of witnesses." (A.J.S. at 49a-50a); 402 F. Supp. at 1053 (footnote omitted).[5]

The District Court declared the challenged statutory provisions unconstitutional and enjoined their enforcement.

5. The court noted that it did not "intend nor expect that all of these procedures will be required every time an attempt to institutionalize a child is made." (A.J.S. at 50a), n. 26; 402 F. Supp. at 1053. With the exception of the rights to notice and counsel, these rights may be waived by the child (or, in some specified circumstances, by counsel) upon approval by the unbiased tribunal. *Id.*



## THE QUESTIONS ARE INSUBSTANTIAL

### I. The District Court Was Correct in Holding that Parents, Guardians and Persons in Loco Parentis Who Seek Mental Commitment of Their Juvenile Wards Cannot Waive the Rights of These Juveniles to Substantial Procedural Protections Prior to Involuntary Indeterminate Institutionalization.

A. *The District Court was correct in holding that the requirements of due process apply to mental commitment proceedings for juveniles.*

The challenged statutes are totally devoid of procedural protections to assure that juveniles are not erroneously committed to mental institutions. The state accepts juveniles for institutionalization simply upon application by parents, guardians and persons in loco parentis. No notice, counsel or hearing is required.[6] Confinement can last for years.

It is beyond dispute that the state must provide substantial procedures to protect persons from erroneous commitment to mental institutions:

> There can be no doubt that involuntary commitment to a mental hospital, like involuntary confinement of an individual for any reason, is a deprivation of liberty which the state cannot accomplish without due process of law. Specht v. Patterson, 386 U.S., at 608, 18 L.Ed 2d 326, 87 S.Ct. 1209. Cf. In re Gault, 387 U.S. 1,

6. After this litigation was begun, the defendant state officials promulgated regulations which, only for those juveniles 13 and older, permit a hearing, but "do not provide a time by which a commitment hearing must be held. * * * With respect to children 12 years of age or younger, there is no requirement for a hearing, no less a designated time." (A.J.S. at 27a), n. 5; 402 F. Supp. at 1043, n. 5.

> 12-13, 18 L.Ed 2d 527, 87 S.Ct. 1428 (1967). Commitment must be justified on the basis of a legitimate state interest, and the reasons for committing a particular individual must be established in an appropriate proceeding.

*O'Connor v. Donaldson*, — U.S. —, 95 S.Ct. 2486, 45 L.Ed. 2d 396, 410 (1975) (Chief Justice Burger, concurring). This Court, in recent years, has consistently upheld claims by inmates of mental institutions to hearing and other procedures protective of their constitutional rights. *Baxstrom v. Herold*, 383 U.S. 107 (1966); *Specht v. Patterson*, 386 U.S. 605 (1967); *Jackson v. Indiana*, 406 U.S. 715 (1972); *Humphrey v. Cady*, 405 U.S. 504 (1972); *McNeil v. Director, Patuxent Institution*, 407 U.S. 245 (1972).[7]

This Court's deep concern that due process be afforded to the mentally disabled is by no means newly conceived. Nearly sixty years ago, in *Chaloner v. Sherman*, 242 U.S. 455 (1917), a challenge was made to state mental incompetency procedures. Speaking for a unanimous Court, Justice Brandeis declared:

> As the plaintiff had notice and opportunity to be heard at each stage of these proceedings, the essential ele-

7. The lower federal courts have uniformly upheld the application of due process to mental commitments, mandating procedures similar or identical to those required by the District Court here. *E.g., Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972) (Three-Judge Court), *vacated and remanded on other grounds*, 414 U.S. 473 (1974), *on remand*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated and remanded on other grounds*, 95 S.Ct. 1943 (1975); *Lynch v. Baxley*, 386 F. Supp. 378 (M.D. Ala. 1974) (Three-Judge Court); *Bell v. Wayne County*, 384 F. Supp. 1085 (E.D. Mich. 1974) (Three-Judge Court); *Kendall v. True*, 391 F. Supp. 413 (W.D. Ky. 1975) (Three-Judge Court); *Dixon v. Attorney General of the Commonwealth of Pennsylvania*, 325 F. Supp. 966 (M.D. Pa. 1971); *Heryford v. Parker*, 396 F.2d 393 (10th Cir. 1968); *In Re Ballay*, 482 F.2d 648 (D.C. Cir. 1973); *In Re Basso*, 299 F.2d 933 (D.C. Cir. 1962); *In Re Barnard*, 455 F.2d 1370 (D.C. Cir. 1971); *Sarzen v. Gaughan*, 489 F.2d 1076 (1st Cir. 1973).



> ments of due process of law were fully met, and the court had jurisdiction to enter that order.

242 U.S. at 455. See also *Dexter v. Hall*, 82 U.S. 9, 25 (1872) (". . . a lunatic needs more protection than a minor." "Both such classes of persons are regarded as under the protection of the law."); *Lynch v. Overholser*, 369 U.S. 705, 735 (1962) (federal law indicates "awareness that Congress has otherwise shown for safeguarding those suspected of mental incapacity against improvident confinement.")

It has never been held that, despite the above authority, juveniles are not entitled to a due process hearing prior to mental commitment. In fact, the cases hold that juveniles are so entitled.[8]

It is the fact of incarceration—whether for mental disability or delinquency or any other reason—which triggers the need for a stringent fact-finding process. *Appli-*

8. *Saville v. Treadway*, 404 F. Supp. 430 (M.D. Tenn. 1974), described in District Court Opinion, A.J.S. at 31a, n. 7; 402 F. Supp. at 1045, n. 7. In *Heryford v. Parker*, 396 F.2d 393 (10th Cir. 1968), the Tenth Crcuit held that a nine-year old child committed to a training school for the feeble-minded and epileptic was entitled to a due process hearing similar to that required in the case at bar. See *Kidd v. Schmidt*, — F. Supp. — (E.D. Wis., August 15, 1975) (held that juvenile mental patients are entitled to preliminary injunction against parental commitment statutes).

In *Francklyn v. Sprague*, 121 U.S. 215 (1887), where a "lunacy proceeding" was brought in court against a juvenile, this Court recognized that such actions were proper:

> In Shelford on Lunacy it is said: "It seems, that a commission of lunacy may issue against an infant; but as the court of chancery has power over infant wards of court and their estates, such a proceeding seems unnecessary during the minority of the ward, except under particular circumstances when the more ample powers given in lunacy may be required for managing their estates." In Stock on Non Compos Mentis, it is also said, that, "Infancy is not a ground for withholding a [commission of lunacy], except in so far as it renders such a proceeding unnecessary, by subjecting the infant to another protective power of the Chancellor.

121 U.S. at 229 (brackets in original).

*cation of Gault*, 387 U.S. 1 (1966); *McKeiver v. Pennsylvania*, 403 U.S. 528, 543 (1971). That its purpose is rehabilitative treatment does not exempt the state from the requirements of due process:

> Nor does the fact "that the purpose of the commitment is rehabilitative and not punitive . . . change its nature. . . . Regardless of the purpose for which incarceration is imposed, the fact remains that it is incarceration. The rehabilitative goals of the system are admirable, but they do not change the drastic nature of the action taken. Incarceration of adults is also intended to produce rehabilitation."

*Breed v. Jones*, 421 U.S. 519, n. 12 (1975), quoting with approval, *Fain v. Duff*, 488 F.2d 218, 225 (5th Cir. 1973).

B. *Parents, guardians and persons in loco parentis cannot waive the personal constitutional rights of juveniles.*

While this Court has repeatedly required that juveniles' constitutional rights be protected from infringement, former cases have usually not presented a situation where the interests of parents or guardians were aligned with the state against those of juveniles.[9] Where cases have presented such interest conflicts, this Court has held, as did the District Court here, that parents and guardians cannot act to waive or prejudice the rights of their children and wards. In *Bank of the United States v. Ritchie*, 33 U.S. 128 (1834), per Chief Justice Marshall, the Court held that a minor's guardian cannot consent, absent hearing and proof before a court, to the relief sought in a proceeding against the child. See *Hoyt v. Hammekin*, 55 U.S. 346, 351 (1852)

9. See, *e.g.*, *Haley v. Ohio*, 332 U.S. 596, 601 (1948); *Gallegos v. Colorado*, 370 U.S. 49, 54 (1962); *Kent v. United States*, 383 U.S. 541 (1962); *Application of Gault*, 387 U.S. 1 (1966); *Wisconsin v. Yoder*, 406 U.S. 205 (1972); *Tinker v. Des Moines Independent School District*, 393 U.S. 503 (1969); *Goss v. Lopez*, 42 L. Ed. 2d 725, 95 S.Ct. 729 (1975).



("A guardian cannot dispose of the property of his ward without the permission of the judge of his domicil."); *O'Hara v. MacConnell*, 93 U.S. 150 (1876) (Court must assure that minor has independent representation in proceeding to deprive her of property; notice and opportunity to be heard required); *Wyman v. James*, 400 U.S. 309, 318 (1971) ("The dependent child's needs are paramount, and only with hesitancy would we relegate those needs, in the scale of comparative values, to a position secondary to what the mother claims as her rights.")[10]

The "state has a wide range of power for limiting parental freedom and authority in things affecting the child's welfare," *Prince v. Massachusetts*, 321 U.S. 158, 167 (1944). Where, as found by the District Court, parents and guardians, in deciding to commit their children, may be acting against the interest of their children,[11] parental and governmental authority must yield to the fact-finding processes required in mental commitments by the Constitution. A child's welfare cannot always be left to a child's parents:

> Unfortunately, experience has shown that the question of custody, so vital to a child's happiness and well-being, frequently cannot be left to the discretion of parents.

10. The earliest high court case found by counsel involving a conflict between parent and child is *Respublica v. Keppele*, 2 U.S. 197 (1793) (Pa. Sup. Ct.), where it was held that a parent could not bind a child as a servant.

This Court has had frequent experience with cases in which the property rights of minors have been protected by representation independent of the guardian. *Insurance Company v. Bangs*, 103 U.S. 435 (1380); *United States v. Dunn*, 268 U.S. 121 (1925); *Clarke v. Clarke*, 178 U.S. 186, 193-195 (1900). See also *United States v. Equitable Trust Company of New York*, 283 U.S. 738 (1931) (in lower courts, one court-appointed guardian acted to protect mentally incompetent person from actions of wife and another court-appointed guardian).

11. A.J.S. at 36a-37a; 402 F. Supp. at 1047-1048 (citations omitted).

*Ford v. Ford*, 371 U.S. 187, 194 (1962).

There is no way—and appellants have suggested none—in which parental waiver of a child's right to liberty[12] can be found to be an "intentional relinquishment or abandonment of a known right or privilege," *Johnson v. Zerbst*, 304 U.S. 458, 464 (1938), when it is the parent or guardian (together with the state) who seeks to restrict the child's liberty. See *Brady v. United States*, 397 U.S. 742, 748 (1970). See also *Massey v. Moore*, 348 U.S. 105 (1954) (waiver of rights by mentally ill person, unaided by counsel).[13]

In several important cases beginning in 1923, this Court has examined the extent to which the Constitution affects the rights of children and the triangular relationship of parent-child-state. The Court has confirmed that the Constitution protects all persons, regardless of age, and has impressed a constitutional endorsement upon the proposition, detailed above, that parental authority may be restricted for the benefit of the child. These cases do not support appellants' unprecedented claim that parental waiver is permitted.

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12. Mental commitment raises an "important question concerning every man's constitutional right to liberty." *O'Connor v. Donaldson*, — U.S. —, 45 L.Ed. 2d 396, 405 (1975).

13. Even if a parent or guardian, in this context, possesses some quantum of capacity to waive a child's rights, that waiver cannot be accomplished simply by the act of committing the child to an institution. Questions of waiver must be determined by the court:

> The constitutional right of an accused to be represented by counsel invokes, of itself, the protection of a trial court, in which the accused—whose life or liberty is at stake—is without counsel. This protecting duty imposes the serious and weighty responsibility upon the trial judge of determining whether there is an intelligent and competent waiver by the accused. While the accused may waive the right to counsel, whether there is a proper waiver should be clearly determined by the trial court and it would be fitting and appropriate for that determination to appear upon the record.

*Johnson v. Zerbst*, 304 U.S. 458, 465 (1938).



*Meyer v. Nebraska*, 262 U.S. 390 (1923), involved what the Court later called "children's rights to receive teaching in languages other than the nation's common tongue." *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944). In *Meyer*, the Court declared the familiar principle that state interests must often yield to individual rights. 262 U.S. at 401.

Two years later, when a criminal law requiring parents to send children to public schools was challenged, it was only after noting the contention that the law violated "the right of the child to influence the parents' choice of a school," *Pierce v. Society of Sisters*, 268 U.S. 510, 532 (1925), that the familiar gloss, relied on by appellants, was made that the law unreasonably interferes with the liberty of parents and guardians to direct the upbringing and education of children under their control. *Id.* at 534-535. However, the possible breadth of this language in *Pierce* was substantially limited in *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944), when the Court upheld restrictions on the rights of guardians and approved appropriate regulation of family interests.

*Ginsberg v. New York*, 390 U.S. 629 (1968), is not contrary authority. First, *Ginsberg* dealt with obscenity which is *not* constitutionally protected; the liberty of the juveniles in the case at bar, on the other hand, *is* subject to constitutional protection. Second, the Court recognized the narrowness of the issue before it when it declared that it was not considering

> the impact of the guarantees of freedom of expression upon the totality of the relationship of the minor and the State, cf. In re Gault, 387 U.S. 1, 13.

390 U.S. at 636. Third, the Court held only that the Constitution supports the parents' "claim to authority *in their own household*" to direct the rearing of children, 390 U.S. at 639 (emphasis added); this cannot be read as authority for absolute discretion outside the household and, indeed, the Court in *Ginsberg* continued to hold that the state must

protect children from abuses. 390 U.S. at 640. Certainly, wrongful commitment is such an abuse.

In *Wisconsin v. Yoder*, 406 U.S. 205 (1971), limitations on parental powers continued to receive approval; such regulation is proper "if it appears that parental decisions will jeopardize the health or safety of the child, or have a potential for significant social burdens." 406 U.S. at 234. The decision of the District Court that erroneous commitment of juveniles to mental institutions creates a significant social burden and can be injurious to juveniles is clearly consistent with prior decisions of this Court.

## II. The District Court Did Not Abuse Its Discretion in Requiring the Defendant State Officials to Assure That Juveniles Presently Committed Receive Constitutional State Procedures to Determine Whether They are Mentally Disabled and in Need of Institutionalization.

The District Court ordered the defendant state officials to initiate procedures to assure that all juveniles committed without hearings or counsel under the unconstitutional statutes receive the benefit of "accurate fact-finding." *McKeiver v. Pennsylvania*, 403 U.S. 528, 543 (1971), in a state forum.[14]

Appellants' assertion that *Preiser v. Rodriguez*, 411 U.S. 475 (1972), and *Wolff v. McDonnell*, 418 U.S. 539 (1973), bar such relief is based on a misreading of those cases and a failure to note other actions of this Court which support the District Court's order.

*Preiser* and *Wolff* held that litigants could not obtain from the federal courts, in actions under 42 U.S.C. §1983, relief affecting "the fact or duration of confinement" or effecting "immediate or a speedier release."[15] *Wolff* noted

14. A.J.S. at 105a-106a (Paragraph 15 E).
15. *Preiser v. Rodriguez*, 411 U.S. 475, 500 (1973).



that "an injunction restoring good time improperly taken is foreclosed" but specifically permitted federal courts to "fashion appropriate remedies for any constitutional violations ascertained, short of ordering the actual restoration of good time already canceled."[16]

The District Court faithfully followed *Wolff*'s proscription. It did not order "actual restoration" of liberty to plaintiffs and their class; it simply ordered that the defendant welfare department officials assure that proper state proceedings be afforded persons who had never had them. It would be in these state proceedings (not in the federal court) that commitment determinations would be made. The alternative to this orderly process would have been to allow the possibly erroneous commitment of thousands of persons to stand.

This Court's decision in *Gerstein v. Pugh*, 420 U.S. 103 (1975), directly supports the District Court and explains the error in appellants' argument:

> Respondents did not ask for release from state custody, even as an alternate remedy. They asked only that the state authorities be ordered to give them a probable cause determination. This was also the only relief that the District Court ordered for the named respondents. 332 F. Supp. at 1115-1116. Because release was neither asked nor ordered, the lawsuit did not come within the class of cases for which habeas corpus is the exclusive remedy. *Preiser v. Rodriguez*, 411 U.S. 475, 93 S. Ct. 1827, 36 L.Ed. 2d 439 (1973); see *Wolff v. McDonnell*, 418 U.S. 539, 554, 94 S.Ct. 2963, 2973, 41 L.Ed. 2d 935 (1934).

*Id.* at n. 6.[17] See *Gomez v. Miller*, 341 F. Supp. 323 (S.D. N.Y. 1972), *aff'd sub nom.*; *Miller v. Gomez*, 412 U.S. 914

16. *Wolff v. McDonnell*, 418 U.S. 539, 555 (1974).
17. In *Gerstein*, as in this case, persons were deprived of their liberty for a substantial period without a probable cause hearing. The relief granted in *Gerstein*, as in this case, assured constitutional proceedings in a state forum.

(1973) (class action challenging constitutionality of pretrial confinement in state mental hospital for the criminally insane; relief sought and upheld was a state "determination of dangerousness as a prerequisite to retention").[18]

Principles of federalism were similarly respected by the District Court. No state proceedings were interfered with; in fact, the state executive, judicial and legislative branches are left free to continue commitment of juveniles, so long as the procedures used do no violate the Constitution.[19]

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18. See *Hartman v. Scott*, 488 F.2d 1215 (8th Cir. 1973); *Bradford v. Weinstein*, 519 F.2d 728 (4th Cir. 1974), *appeal dismissed on other grounds*, — U.S. —, 46 L.Ed. 2d 350 (1975); *Joyce v. Gilligan*, 383 F. Supp. 1028 (N.D. Ohio 1974); *Winegard v. State of North Carolina*, 366 F. Supp. 983 (W.D. N.C. 1973); *United States ex rel. Johnson v. Chairman of the New York State Board of Parole*, 363 F. Supp. 416 (E.D. N.Y. 1973).

Appellants' reliance on *Kendall v. True*, 391 F. Supp. 413 (W.D. Ky. 1975), is misplaced. The case did not consider or discuss the *Preiser* issue. Also, the plaintiff mental patients in *Kendall* were incarcerated under a statute which provided for a maximum hospital term of 60 days and under which a judicial hearing and counsel were provided. Here, the plaintiffs are under an indeterminate term and have had no hearing or counsel.

Both *Lessard v. Schmidt*, *supra*, and *Lynch v. Baxley*, *supra*, provided relief for persons presently incarcerated in violation of the Constitution. Such "retrospective" application of a rule going to the heart of fact-finding procedures is proper. *E.g.*, *Kitchens v. Smith*, 401 U.S. 847 (1971); *V. v. New York*, 407 U.S. 203 (1972).

19. The defendant state executive officials were ordered to "initiate procedures;" these could include both administrative mechanisms of their own choosing as well as use of the state habeas corpus statute, 50 P.S. §4426.

The District Court, in its opinion and final order, specifically noted its deference to the principles enunciated most recently by this Court in *Rizzo v. Goode*, — U.S. —, 44 U.S.L.W. 9095 (1976). The District Court explained:

> As we have already noted, due process is flexible; the Constitution mandates no specific code of procedures. We are aware of the problems facing courts when they attempt to fashion procedures protecting language of the Fourteenth Amendment and we are sensitive to the claim that courts are



## III. The District Court's Requirement of Constitutional State Procedures for Persons Presently Committed Does Not Violate the Eleventh Amendment.

The appellants argue that the District Court violated the Eleventh Amendment when it ordered[20] that persons presently incarcerated unconstitutionally be provided state procedures to determine whether they require commitment. In a two-fold analysis, appellants claim 1) that affirmative exercise of the sovereign's power is barred and 2) that the cost or providing this relief to juveniles presently incarcerated without hearings may not be imposed on the state.[21] The Eleventh Amendment dictates no such result.

The Eleventh Amendment bars suits by citizens against unconsenting states. *Hans v. Louisiana*, 134 U.S. 1 (1890). However, federal courts have undoubted authority to entertain suits against state officials where they act unconstitutionally, *Ex Parte Young*, 209 U.S. 123 (1908).

In the case at bar, the enforcement of Pennsylvania's commitment law was found unconstitutional. Therefore, appellants err in their reliance on *Hawaii v. Gordon*, 373

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> "good at deciding cases, bad at drafting legislation. . . ." See, Friendly, J. "Some Kind of Hearing," supra. When presented with claims of constitutional dimension, however, we are constrained, when legislative bodies have failed to act, to find means of enforcing the constitutional rights being denied. Our action is not intended to pre-empt the state which is free to develop its own safeguards so long as they are as fully effective as those which we set out. See Miranda v. Arizona, 384 U.S. 436, 490, 86 S.Ct. 1602, 16 L.Ed. 2d 694 (1966); Morrissey, 408 U.S. at 490, 92 S.Ct. 2593.

A.J.S. at 39a, n. 16; 402 F. Supp. at 1048-1049, n. 16. The legislature is free to develop an alternate constitutional system. A.J.S. at 41a, n. 18, 42a, n. 19, 100a, 101a; 402 F. Supp. at 1049, n. 18 and 1050, n. 19.

20. A.J.S. at 105a (Paragraph 15E).

21. Appellants do not assert that any of the injunctive relief granted by the District Court as to future commitments violates the Eleventh Amendment.

U.S. 57 (1963); *Dugan v. Rank*, 372 U.S. 609 (1963); *Malone v. Bowdoin*, 369 U.S. 643 (1962); *Ex Parte New York*, 356 U.S. 490 (1921); *Larson v. Domestic & Foreign Commerce Corp.*, 377 U.S. 682 (1949); *Land v. Dollar*, 330 U.S. 731 (1947). In *none* of these cases did plaintiffs allege that the defendant government officials' conduct was unconstitutional.[22] None of these cases supports the broad proposition that the Eleventh Amendment bars assurance of due process fact-finding procedures in a state forum.

The District Court did not award damages or "equitable restitution" of funds from the state treasury; expenditure of state funds to implement the decree is incidental to the constitutionally mandated goal of assuring

22. An original action against the Director of the Bureau of the Budget was dismissed per curiam in *Hawaii v. Gordon, supra;* no constitutional violations were asserted.

In *Larson, supra*, this Court held that sovereign immunity barred an injunction against the Administrator of the War Assets Administration. The Court held:

> There is no claim that his action constituted an unconstitutional taking. It was, therefore, inescapably the action of the United States and the effort to enjoin it must fail as an effort to enjoin the United States.

337 U.S. at 703 (note omitted). The Court's dictum at 337 U.S. at 691, n. 11, must be read along with the text which permits restraint of "state officers seeking to enforce unconstitutional enactments."

*Dugan v. Rank, supra*, involved the statutory authority of federal Reclamation Bureau officials. The Court held the suit barred, noting the fact that no challenge was made to the constitutionality of the government's actions. 372 U.S. at 621-622.

A common law action of ejectment against a federal forest officer was the basis of *Malone v. Bowdoin*, 369 U.S. 643 (1962). The suit did not claim unconstitutional activities.

*Ex Parte New York, supra*, held that the Eleventh Amendment bars an unconsented admiralty suit *in personam* against a state.

*Land v. Dollar, supra*, determined that public officials could be sued when they exceed the limits of their authority.

The lower court cases cited by appellant at 25, n. 4 of their Jurisdictional Statement similarly fail to support their contentions.



that persons are not erroneously incarcerated. This Court has frequently required equitable relief having substantial fiscal impact on a state. Such impact, held *Edelman v. Jordan*, 405 U.S. 651, 667-668 (1974), is not barred by the Eleventh Amendment:

> The injunction issued in Ex parte Young was not totally without effect on the State's revenues, since the State law which the Attorney General was enjoined from enforcing provided substantial monetary penalties against railroads which did not conform to its provisions. Later cases from this Court have authorized equitable relief which has probably had greater impact on state treasuries than did that awarded in Ex parte Young. In Graham v. Richardson, 403 U.S. 365 (1971), Arizona and Pennsylvania welfare officials were prohibited from denying welfare benefits to otherwise qualified recipients who were aliens. In Goldberg v. Kelly, 397 U.S. 254 (1970), New York City welfare officials were enjoined from following New York State procedures which authorized the termination of benefits paid to welfare recipients without prior hearing. But the fiscal consequences to state treasuries in these cases were the necessary result of compliance with decrees which by their terms were prospective in nature. State officials, in order to shape their official conduct to the mandate of the Court's decrees, would more likely have to spend money from the state treasury than if they had been left free to pursue their previous course of conduct. Such an ancillary effect on the state treasury is a permissible and often an inevitable consequence of the principle announced in Ex parte Young, supra.[23]

23. *Ad Hoc Committee on Judicial Administration v. Massachusetts*, 488 F.2d 1241, 1243, n. 2 (1st Cir. 1973), cited for the opposite proposition by appellants, actually supports affirmative relief to remedy constitutional violations:

> Courts have not limited the Ex parte Young doctrine to "negative" relief, and have often ordered positive governmental

415 U.S. at 667-668 (note omitted). Surely "equitable restitution" of funds directly to plaintiffs, held in *Edelman* to resemble monetary damages, is a far cry from requiring compliance with procedural due process.

To the extent that the District Court determined that the protection of its order must be applied retroactively to persons presently incarcerated, it was clearly correct. See *V. v. City of New York*, 407 U.S. 203 (1972), holding *In re Winship*, 397 U.S. 358 (1970), retroactive; *Kitchens v. Smith*, 401 U.S. 847 (1971), holding *Gideon v. Wainwright*, 372 U.S. 335 (1963), retroactive, It has never been held that the cost of "truth-finding"[24] proceedings was barred by the Eleventh Amendment.

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Note 23—*Continued*

action. In cases involving deprivation of constitutionally protected rights, "affirmative" relief has been granted, notwithstanding the fact that the incidental effect is that the state will be forced to expend funds from its treasury. *See, e.g., Graham v. Richardson*, 403 U.S. 365, 91 S. Ct. 1848, 29 L.Ed. 2d 534 (1971); *Gideon v. Wainwright*, 372 U.S. 335, 83 S.Ct. 792, 9 L.Ed. 2d 799 (1963); *Inmates v. Eisenstadt*, 360 F. Supp. 676 (D. Mass. 1973); *Martarella v. Kelley*, 349 F Supp. 575 (S.D. N.Y. 1972).

24. *V., supra*, 407 U.S. at 204, quoting *Williams v. United States*, 401 U.S. 646, 653 (1971).



THERE IS NO CONFLICT AMONG THE COURTS

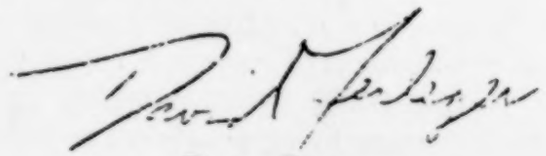
As the preceding discussion indicates, there is absolutely no conflict among the federal courts on any of the issues raised by appellants, on the merits or on the relief.[25]

A number of cases similar to the case at bar are pending in federal district courts. *E.g., Kidd v. Schmidt*, — F. Supp. — (E.D. Wis., August 15, 1975) (held that juvenile mental patients are entitled to preliminary injunction against parental "voluntary" commitment statutes) (Three-Judge Court); *J.L. & J.R., Minors v. Parham*, No. 75-163-MAC M.D. Ga.) (Three-Judge Court); *Poe v. Weinberger*, C.A. No. 74-1800 (D.D.C.) (Three-Judge Court) (class determined); *Campbell v. Director of the Michigan Department of Mental Health*, Civ. No. 572318 (E.D. Mich.) (Three-Judge Court requested); *White v. Director of the Michigan Department of Mental Health*, Civ. No. 7510022 (E.D. Mich.) (Three-Judge Court). It would be inappropriate, in these circumstances, for this Court to decide this case.

## CONCLUSION

For the foregoing reasons, it is respectfully submitted that the appellants present no substantial question for the decision of this Court and that the judgment and decree of the District Court should be affirmed.

Respectfully submitted,



DAVID FERLEGER
*Counsel for Appellees*

February 23, 1976

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25. The Court's attention is directed to a commentary which supports the District Court's decision on the merits. Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 Calif. L. Rev.

IN THE
SUPREME COURT OF THE UNITED STATES

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October Term, 1975

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No. 75-1064

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Jack B. Kremens, *et al.*,

*Appellants*

*v.*

Kevin Bartley, *et al.*,

*Appellees*

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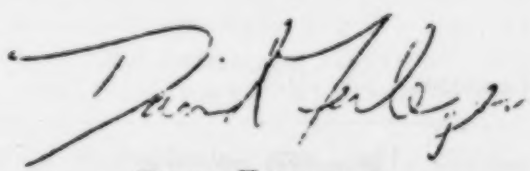
## CERTIFICATE OF SERVICE

---

I, DAVID FERLEGER, Counsel for Appellees, do hereby certify that I have served by United States Mail, postage prepaid, first class, on this date, Friday, February 27, 1976, three copies of Appellees' Motion to Affirm to Norman J. Watkins, Deputy Attorney General, Counsel for Appellants, at Department of Justice, Capitol Annex, Harrisburg, Pennsylvania, 17120. I further certify that all parties required to be served in this appeal have been served.



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Supreme Court, U. S.
FILED
JUN 16 1976
MICHAEL RODAK, JR., CLERK

# In the Supreme Court of the United States

No. 75-1064

JACK B. KREMENS, Individually and as Hospital Director of Haverford State Hospital; FRANK S. BEAL, Individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; WILLIAM B. BEACH, JR., Individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,

Appellants

v.

KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND; Minors, Through Their Next Friend, Individually and on Behalf of All Others Similarly Situated,

Appellees

Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania.

## BRIEF FOR APPELLANTS

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## ERRATA

BRIEF FOR APPELLANTS

No. 75-1064

Jack B. Kremens, et al.

v.

Kevin Bartley, et al.

Page iv—Second line from the bottom, 28 U.S.C. §2281 rather than §22811.

Page 19—Last line of second full paragraph should read §2281 rather than §22811.

Page 38—Fourth line of last paragraph should read: "Moreover, proof of delinquency must meet the traditional heavy burden of beyond a reasonable doubt." rather than ". . . must *not* meet . . . ."

Page 55—Last line of first paragraph should read ". . . conclusion in Edelman exist and apply in this case."

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* Appellants examined in excess of thirty (30) state statutes similar to those brought into question in this case which are cited at p. 27, infra.



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## OPINIONS BELOW

The majority and dissenting opinions of the District Court are reported at 402 F. Supp. 1039. Copies of the opinons are set forth in the Appendix at (783a-823a).

## JURISDICTION

The decision of the District Court and its final order were entered on November 17, 1975. *Bartley v. Kremens,* 402 F. Supp. 1039. A notice of appeal was filed on November 28, 1975. Probable jurisdiction was noted on March 22, 1976.

The jurisdiction of this Court is conferred by Title 28, United States Code, Section 1253.

## STATUTES AND REGULATIONS INVOLVED

### STATUTES

Mental Health and Mental Retardation Act of 1966,
50 P.S. §4402 et seq.

§4402. **Voluntary admission; application, examination and acceptance; duration of admission**

(a) Application for voluntary admission to a facility for examination, treatment and care may be made by:

(1) Any person over eighteen years of age.

(2) A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.

(b) When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he may be admitted.

(c) Except where application for admission has been made under the provisions of section 402(a) (2) and the person admitted is still eighteen years of age or younger, any person voluntarily admitted shall be free to withdraw at any time. Where application has been made under the provisions of section 402(a) (2), only the applicant or his successor shall be free to withdraw the admitted person so long as the admitted person is eighteen years of age or younger.



(d) Each admission under the provisions of this section shall be reviewed at least annually by a committee, appointed by the director from the professional staff of the facility wherein the person is admitted, to determine whether continued care is necessary. Said committee shall make written recommendations to the director which shall be filed at the facility and be open to inspection and review by the department and such other persons as the secretary by regulation may permit.

Where the admission is under the provisions of section 402(a) (2), the person admitted shall be informed at least each sixty days of the voluntary nature of his status at the facility.

§4403. **Voluntary commitment; application, examination and acceptance; duration of commitment**

(a) Application for voluntary commitment to a facility for examination, treatment and care may be made by:

(1) Any person over eighteen years of age.

(2) A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.

(b) The application shall be in writing, signed by the applicant in the presence of at least one witness. When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he shall be committed for a period not to exceed thirty days. Successive applications for continued voluntary commitment may be made for successive periods

not to exceed thirty days each, so long as care or observation is necessary.

(c) No person voluntarily committed shall be detained for more than ten days after he has given written notice to the director of his intention or desire to leave the facility, or after the applicant or his successor has given written notice of intention or desire to remove the detained person.

(d) Each commitment under the provisions of this section shall be reviewed at least annually by a committee, appointed by the director from the professional staff of the facility wherein the person is cared for, to determine whether continued care and commitment is necessary. Said committee shall make written recommendations to the director which shall be filed at the facility and be open to inspection and review by the department and such other persons as the secretary by regulation shall permit.

Where the commitment is under the provisions of section 403 (a) (2), the person committed shall be informed at least each sixty days of the voluntary nature of his status at the facility.

§4405. **Commitment for emergency detention**

(a) Whenever a person appears, by reason of his act or threatened acts, to be so mentally disabled as to be dangerous to himself or others and in need of immediate care, he may be taken into custody for the purpose of examination, provided that:

(1) Only a relative, guardian, friend, individual standing in loco parentis to the person believed to be mentally disabled, executive Officer or authorized



agent of a governmental or recognized nonprofit agency providing health or welfare services, or a police officer may take such person into custody and then only upon written application approved by the administrator or his delegate, and

(2) The acts or threats which give cause to believe the person to be mentally disabled and in need of immediate care are overt, demonstrate a clear and present danger to self or others and are set forth in the application.

(b) Immediately upon being taken into custody, such person shall be taken with the approved application for examination to a physician or designated facility for examination on an emergency basis: (i) When examination is made by a physician who determines that such person is in need of immediate emergency care in a facility, he shall so certify on the aforementioned application and upon request, local police or State police shall forthwith transport such person to such designated facility where application shall be presented, the certificate filed with the facility, and the person thereby committed for emergency care. (ii) When the examination is made at a designated facility and it is determined by an examining physician that the person is in need of immediate emergency care, the examining physician shall file the required certificate and the commitment of such person for emergency care thereby shall be effected.

(c) When the application is not made by a relative or the guardian, the director, upon reception of the person named in the application, shall notify the appropriate relative or the guardian of the commitment of such person.

(d) If the examining physician shall determine that any person taken into custody by a police officer is not in need of immediate emergency care in a facility, and the person in custody has committed a criminal act, the police officer shall take such person to the proper issuing authority to be dealt with according to law. In all other cases such person shall be returned to the place where he was taken into custody and released.

(e) No person who proceeds under the provisions of this section shall be held civilly or criminally liable therefor, unless he acted maliciously and did not have probable cause to believe that the person taken into custody was suffering from mental disability.

(f) Any person committed under this section may be detained for a period of not more than ten days. If during this period the director finds that such person requires further care, he may admit the person on a voluntary commitment or notify the applicant (other than a police officer), or the administrator of the county of the person's residence, to make further application for such person's commitment under other provisions of this act.

§4406. **Civil court commitment**

(a) Whenever a person is believed to be mentally disabled, and in need of care or treatment by reason of such mental disability, and examination of such person has been made by a physician or physicians, or for any reason the examination of such person cannot be made, a petition may be presented to the court of common pleas of the county in which a person resides or is, for his immediate examination or commitment to an appropriate facility for examination, observation and diagnosis.



(1) The petition may be made by a relative, guardian, friend, individual standing in loco parentis or by the executive officer or an authorized agent of a governmental or recognized nonprofit health and welfare organization or agency of any responsible person.

(2) The petition shall set forth the facts upon which the petitioner bases his belief of mental disability and the efforts made to secure examination of the person by a physician.

(3) Said court upon consideration of such petition shall: (i) issue a warrant requiring that such person be brought before said court; (ii) fix a date for a hearing which shall be as soon as the warrant is executed, and (iii) notify the parties in interest.

(4) After hearing, said court may: (i) order an immediate examination by two physicians appointed by said court, or (ii) order the commitment of the person believed to be mentally disabled, to a facility for a period not exceeding ten days for the purpose of examination. If the examination can be accomplished by partial hospitalization said court may so direct.

(b) If, upon examination, it is determined that such person is in need of care at a facility, the examining physicians or director, as the case may be, shall immediately report to said court which may order the commitment of such person for care and treatment.

In its order of commitment, said court may permit partial hospitalization or outpatient care, or if at any time thereafter the director shall determine such partial hos-

pitalization or outpatient care to be beneficial to the person so committed, the same may be permitted by said court upon application by the director.

§4426. **Habeas corpus; discharge by order of court**

(a) Every person committed or detained in a facility by reason of the provisions of this act or anyone acting on his behalf, may at any time, petition for a writ of Habeas Corpus and, except as hereinafter provided, said petition shall be filed in accordance with the provisions of the act of May 25, 1951 (P.L. 415).

(b) Said petition may be based upon the following grounds:

(1) The insufficiency or illegality of the proceedings leading to such person's commitment, or,

(2) Although the commitment proceedings were proper, such person's continued detention or hospitalization is not warranted by reason of mental disability. Where the petition is based on this ground: (i) it shall be accompanied by the affidavit of a physician stating that he has examined the person and is of the opinion that such person is not mentally disabled, or that such mental disability does not require care or treatment in a facility, and (ii) the burden of proof shall rest upon the director responsible for such person's continued detention.

(c) Jurisdiction and venue is hereby conferred upon the several courts of the Commonwealth to issue writs of Habeas Corpus filed under this act as follows:

(1) A petition filed under section 426 (b) (1) may be filed: (i) where committed by a court, only



in the same court, or (ii) where committed under sections 404 or 405 of this act, only in the court of the county where the application for commitment was made.

(2) A petition filed under section 426 (b) (2) may be filed: (i) in the court which committed such person or the court of common pleas of the county where he is detained if a civil commitment was ordered, or (ii) where a criminal charge is pending, in the court having jurisdiction of the charge or which committed him or the court of the county where he is detained, or (iii) where committed by a court where a criminal act was in any way otherwise involved in the proceedings leading to commitment, only in the same court which committed such person.

(3) If any petition under section 426 (b) (2) is filed in a court other than the court of the county in which the person is detained, the petition may be transferred for disposition by the court in which it was filed to the appropriate court of the county in which the person is detained.

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## REGULATIONS

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**Volume 3, Pennsylvania Bulletin, p. 1840**
**Department of Public Welfare**

Additional Procedural Safeguards for Juveniles Admitted to Institutions

The Department of Public Welfare by this Order adopts additional procedural safeguards for juveniles ad-

mitted to institutions pursuant to §402 and §403 of the Mental Health and Mental Retardation Act.

Notice of the proposed rule making was published in 3 Pa. B. 536, March 24, 1973.

After consideration of the views presented by interested persons, the regulations are adopted with some changes. Additions have been made in Paragraphs 1, 2, 6, 7 and the form of notification to permit referral of mentally retarded juveniles to institutions by either a pediatrician, or general physician or psychologist. A new paragraph has been written to reflect whether the juvenile is capable of understanding the notification form. In these regulations, the word "applicant" shall refer to the person who signed the juvenile in while the word "juvenile" shall refer to any youth 18 years of age or younger. Several comments urge that the role of the Public Defender's Office be replaced by a legal service program; however, the Public Defender Act, December 2, 1968 P.L. 1144, (No. 358) §1 *et seq.*, (16 P.S. 9960.6(a), (c), specifically makes the Public Defender responsible for persons who are or may be subject to commitment under the Mental Health and Mental Retardation Act of 1966. To the extent, however, that Legal Services other than the Public Defender are readily available, such Legal Services may be utilized in lieu of the Public Defender's Office and §5, §6 and §9 of these regulations have been changed accordingly. These regulations shall not be interpreted to permit direct intake into state-operated facilities. Although the Department is adopting these regulations, it will evaluate the procedures at the end of six months. If necessary, the Department will at that time hold public hearings.

The regulations hereby adopted are adopted pursuant to Article 2, §201 of the Mental Health and Mental Retardation Act of 1966, Act of October 20, 1966, No. 6, Third Special Session.



The Department of Public Welfare finds:

1. That public notice of intention to adopt the administrative regulations adopted by this Order has been duly given pursuant to §§201 and 202 of the Commonwealth Documents Law (45 P.S. §§1201 and 1202) and the regulations thereunder, 1 Pa. Code, §§7.1 and 7.2.

2. That the adoption of the regulations in the manner provided in this Order is necessary and appropriate for the administration of the Mental Health and Mental Retardation Act of 1966.

The Department of Public Welfare, acting pursuant to the Public Welfare Code, and the Mental Health/Mental Retardation Act of 1966, orders:

(A) The regulations of the Department of Public Welfare are amended to read as set forth in Annex A to this order.

(B) The Secretary of the Department of Public Welfare shall submit this Order and Annex A hereto to the Department of Justice for approval as to legality as required by law.

(C) The Secretary of the Department of Public Welfare shall duly certify this Order and Annex A hereto and deposit same in the Legislative Reference Bureau as required by law.

(D) This order shall take effect upon publication.

(s) _____

Secretary of Public Welfare

## ANNEX A

**Rules Relating to Persons 18 Years of Age or Younger Admitted to Mental Health or Mental Retardation Institutions Pursuant to §§402 and 403 of the Mental Health and Mental Retardation Act**

1. All juveniles aged 18 and younger to be admitted to an Institution must be referred from a recognized medical facility, Mental Health/Mental Retardation therapist or Mental Health Agency; however, mentally retarded juveniles may be referred by either a pediatrician, or general physician or psychologist.

2. This referral must be accomplished by a psychiatric evaluation and that report must indicate with specificity the reasons that the person requires institutional care; however, a medical or psychological evaluation may accompany the referral of a mentally retarded juvenile;

3. The Director of the Institution or his delegate, shall have conducted an *independent* examination of the proposed juvenile, and if his results disagree with the professional's opinion, the Director, or his delegate, shall discharge the juvenile;

4. The telephone number and address of the juvenile's parents or the person who is requesting admission for the juvenile must accompany the referral;

5. Within 24 hours after the juvenile's admission, every youth who is at least 13 years of age must receive written notification (which he signs) explaining his rights indicating that he will be given a status report periodically of his condition; that he can contact by telephone or by mail his parents or the person who requested his admission; and that he will be furnished with the number



of counsel (Public Defender's number; Legal Services) that he can call for representation. An appropriate person shall explain this notice (attached);

6. In the event that a juvenile whose chronological age is 13 or older objects (either orally or in writing) to remaining in the Institution, the Director, or his delegate, *if he feels it is necessary for the youth to remain*, may continue the institutionalization for two business days during which time he shall notify the applicant and the referral unit so that either party may institute a 406 proceeding. During that same two-day period, the Director, or his delegate, shall notify the Public Defender's Office or notify Legal Services readily available of the juvenile's need for legal representation. If a 406 proceeding is begun during the two day period, the juvenile shall remain institutionalized. If the applicant cannot be located and the Director, or his delegate, feels that the juvenile does not require institutionalization, the Director or his delegate, shall direct the Base Service Unit to assume responsibility of providing for the juvenile's aftercare. However, if the Director, or his delegate, feels that the juvenile requires institutionalization, he shall direct the Base Service Unit to file a 406 proceeding within two days after failure to locate the applicant;

7. The juvenile's counsel shall be furnished with the juvenile's evaluation from the referral unit, with a psychiatric evaluation from the Institution, and with a written report of the reasons to institutionalize the juvenile.

8. If the staff members of the facility giving notice to the patient determines that the patient is incapable of understanding the notification, it shall be written on the notification;

9. Juveniles aged 13 and older shall be given the following notice:

RIGHTS OF CHILDREN UNDER §402 and §403

You have currently been admitted to the _____ _____ Institution for observation and treatment. This voluntary admission procedure was instituted by _____ on _____ (date). You can call the applicant at Telephone Number _____ _____or you can write the applicant at _____ _____. The purpose in having you admitted to this facility is to help you overcome problems you are experiencing and to return you to the community as soon as possible. Before we accepted you, you must realize that a (circle which one) psychiatric, medical, or psychological opinion was given to us by _____. Also, the Director of this Institution had a (circle which one) psychiatric, medical, or psychological examination conducted so that he could be thoroughly appraised and certain that you could benefit in receiving care and treatment at this Institution.

If you object to remaining in this Institution, you are advised that we shall contact the Public Defender's Office to make other suitable arrangements to obtain legal counsel for you. We will provide you with the telephone number of the attorney who has been contacted on your behalf. We will require two working days from date of your objection to remain, in order to make certain that you will be afforded counsel. At the same time, the Director, or his delegate, of this Institution shall notify the applicant of his desire to require you (sic) hospitalization for your benefit.



A member of our staff shall explain this written letter to you and we ask you to sign it, which will evidence that you have a copy of this letter and that it has been explained to you in detail. In the event that you have any questions, you can direct them to the person who is explaining this document to you or you may contact this office.

_____

Superintendent's Signature

_____

Patient's Signature

_____

Staff Member's Signature
Giving Notice to Patient

## QUESTIONS PRESENTED

I. Whether a parent, acting on a physician's recommendation has the authority to admit his child to a mental facility without a hearing?

II. Whether the order in this case violates the Eleventh Amendment or alternatively, violates the Rule of *Preiser v. Rodriguez?*



## STATEMENT OF THE CASE

In 1971 and 1972 each of the named plaintiffs in this case was admitted or committed to Haverford State Hospital. These plaintiffs were juveniles ranging in age from fourteen to seventeen at the time of their hospitalization.[1] The commitments were initiated by one or both of the juveniles' parents under the provisions of either Section 402 or 403 of Pennsylvania's Mental Health and Mental Retardation Act of 1966.[2]

As required by the Act, each of the plaintiffs received a complete psychiatric examination to determine whether he or she was in need of care and treatment at the hospital 50 Pa. Stat. Ann. §§402(b), 403(b). However, these children were not provided a hearing where, with the assistance of counsel, they could challenge either the basis of their parents' decision to seek psychiatric in-patient therapy for them or the medical findings and recommendations with respect to the necessity for such treatment.

As a result of their respective admissions and commitments this lawsuit was commenced on November 16, 1972 (23a). This action was brought against the superintendent of Haverford and certain named officials of the

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[1] For the purposes of this brief, the terms "juvenile" and "child" will be used interchangeably and will refer to persons eighteen or younger.

[2] The provisions of these Sections of the Mental Health and Mental Retardation Act of 1966 are fully set forth at pages 2-15 of this brief under the heading "Statutes and Regulations Involved." Moreover, this Act of 1966 throughout the remainder of this brief will simply be referred to as "the Act."

Pennsylvania Department of Public Welfare.[3] Moreover, the plaintiffs brought their claims under the Civil Rights Act and generally challenged the constitutionality of Sections 402 and 403 of the Act.

The plaintiffs have predicated their challenge exclusively on two theories. First it was asserted that the procedure which was used in their hospitalization violated the Due Process Clause of the Fourteenth Amendment. In this respect, it has been contended that the Act is unconstitutional in that it fails to require a broad array of procedural safeguards including the rights of notice, hearing, and appointed counsel if necessary, prior to the child's admission to a mental facility.

Secondly, the plaintiffs have claimed a violation of the Equal Protection Clause. The gravamen of their complaint in this regard is that certain procedural rights generally afforded adults by the Act have been denied them solely because of their status as juveniles. Specifically, they have asserted that the right to discharge themselves from voluntary admission and the right to a pre-commitment hearing, which rights are afforded adults under the Act, have not been afforded juveniles in violation of the Equal Protection Clause (19a-20a). In view of the disposition of this case on due process grounds the court did

[3] This action was brought and maintained as a class action, which class was described by the lower court as ". . . all persons eighteen years of age or younger who have been, are, or may be admitted or committed to mental facilities in Pennsylvania under the Pennsylvania Mental Health and Mental Retardation Act (Act)." Moreover, the court specifically noted that this description was intended to encompass both emotionally ill and mentally retarded children (783a).



not address this claim, and similarly the appellants[4] will not address this issue separately for if there is no Due Process violation the same reasons would necessarily apply to defeat the Equal Protection claim.

This lawsuit does not in any way question the validity or quality of treatment that the plaintiffs received at Haverford State Hospital. The plaintiffs are exclusively challenging the procedure by which they were hospitalized.

Because the questions raised by this action were substantial, and because injunctive relief was sought from the operation of these statutes on the basis of their asserted unconstitutionality, a three-judge court was convened on January 19, 1973, pursuant to the provisions of 28 U.S.C. §22811.

However, shortly after this lawsuit was filed the Pennsylvania Department of Public Welfare promulgated regulations augmenting Sections 402 and 403 as they pertain to juveniles. These regulations greatly expanded the procedural protections afforded juveniles in these situations.[5] Briefly they require not one, but two independent psychiatric, psychological, or medical examinations both of which must conclude that hospitalization is necessary as a condition of continued hospitalization.[6] All children thirteen years of age or older must receive written notice of all his rights under the regulations including the right

[4] To avoid confusion the appellees will continue to be referred to as "plaintiffs" and the appellants as "defendants" throughout the remainder of this brief.

[5] The regulations are set out in full at pages 9-15 of this brief.

[6] For the remainder of this brief "medical" or "psychiatric" examinations are used interchangeably and are intended to also include "psychological" examinations where appropriate.

to be provided free counsel and the right to a hearing if he objects in any manner whatsoever to his continued commitment.

On the basis of constitutional deficiencies still perceived in those regulations, and after a fairly extensive evidentiary record had been created, the lower court, with one judge dissenting, held that Sections 402 and 403 of the Act violated the Due Process Clause of the Fourteenth Amendment (783a-813a). By its final order, entered almost four months after this decision,[7] the Court granted very broad declaratory and injunctive relief to the plaintiffs.

Briefly, the lower court ruled that children of any age were entitled to, and the defendants were required to provide (1) a "probable cause hearing" within seventy-two hours of hospitalization (defendants were required to serve prior written notice of that hearing upon the child and his attorney at least forty-eight hours beforehand); (2) a "post-commitment hearing" within two weeks of hospitalization (with a similar prior notice requirement); (3) "Counsel at all significant stages of the commitment," (4) the right to be present at all hearings and to confront and cross-examine witnesses as well as to present testimony on their own behalf (843a-852a).

The Court further ordered that within 120 days of the entry of its order each of the thousands of children then hospitalized in mental facilities either be discharged or recommitted in accord with the newly mandated procedures.

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[7] While the opinion was handed down on July 24, 1975, it took nearly four months for the parties to present their views on the appropriate relief and for the court to enter its order on November 17, 1975.



Finally, the Court directed that the Commonwealth judicial system provide all the necessary judicial resources to implement this order (846a).

Because of the sweeping nature of the relief granted and because of its overwhelming effect upon the government of Pennsylvania, and finally because of the impact of the decision in a societal context, a stay of this order was sought. On December 16, 1975, this Court granted a stay and this appeal followed. On March 22, 1976, probable jurisdiction over this appeal was noted.

## SUMMARY OF ARGUMENT

I. A. The system of mental health admissions and commitments in Pennsylvania relative to juveniles generally recognizes the rights of the parent, with medical advice, to seek hospitalization for his child. However, regulations promulgated by the defendants do provide substantial protective procedures for children over the age of thirteen. A comparison of similar statutory schemes demonstrates that Pennsylvania compares very favorably in balancing the interests of the child with those of his parent when those interests collide.

B. With the exception of this case and its limited progeny there have been no other mental health cases presenting a conflict between the parent and his child. The lower court failed to recognize this important fact and accordingly found the existence of due process rights for children in one situation: state versus child; and applied those rights in a totally different context—child versus parent and doctor.

C. Juveniles' rights have been recognized by this Court in a very careful and deliberate manner. This Court has attempted to balance the need for accurate fact-finding with the desire for informality in delinquency proceedings. The considerations that have led to the recognition of these rights in the area of juvenile delinquency do not apply to the admission procedure for children to mental facilities. In the latter case the crucial determination is not of guilt or innocence, but rather whether or not a child needs psychiatric in-patient care.



Moreover, the underlying assumptions made by the lower court in ordering a full panoply of procedures are of doubtful validity, and more importantly create a misuse of judicial process. Physicians, not lawyers and judges should prescribe medical treatment. Institutional therapy is but one mode in a full spectrum of treatment and any dissatisfaction with that type of treatment is a social problem that should be dealt with legislatively, not by imposing purposeless judicial proceedings on the treatment process. Accordingly, this Court must reverse the decision of the lower court.

II. A. The retroactive portions of the injunctive relief granted by the lower court violate the Eleventh Amendment. This retroactive relief is no less offensive, in its fiscal impact, than was the order set aside by this Court in *Edelman v. Jordan*, 415 U.S. 651 (1974).

B. Alternatively the lower court's order for retroactive implementation violates the principles of federalism recognized by this Court in *Preiser v. Rodriguez*, 411 U.S. 475 (1973). Clearly the plaintiffs in this case had the complete remedy of habeas corpus available to them and, at the very least, they should not have been permitted to attack the legality of their custody by the means of a civil rights action as opposed to habeas corpus. Finally, these same notions of federalism were totally ignored by the lower court when it ordered that the thousands of hearings required to implement the retroactive portions of this order must be conducted by the Commonwealth Judiciary. The Judiciary was never made a party to these proceedings and there was no constitutional necessity for judicial hearings. Accordingly, the retroactive portions of the lower court's order should be set aside.

## ARGUMENT

## I. A PARENT, ACTING ON A PHYSCIAN'S RECOMMENDATION, HAS THE AUTHORITY TO ADMIT HIS CHILD TO A MENTAL FACILITY WITHOUT A HEARING

### A. The Admission Process: an Overview

There presently are four means by which a person may be civilly committed to a mental health facility in Pennsylvania. The first method is referred to as voluntary admission.[8] By this procedure any adult may apply for admission and any parent or guardian may apply for his child's admission to a mental health facility. However, only after an examination concluding that the prospective patient is in need of care or observation has been completed may the patient be admitted. Moreover, by this procedure every adult patient is free to withdraw from the facility at any time. Juvenile patients, on the other hand, may only be withdrawn by the parent who admitted them.

Secondly, there is the voluntary commitment.[9] This procedure is generally the same as the voluntary admission procedure except that commitments under this section may not exceed thirty days, and ten days written notice to the

[8] 50 Pa. Stat. Ann. §4402. See pp. 2-3, supra, where this section of the Act is set out in full.

[9] See Section 403 at pp. 3-4, supra.



director of the facility is required to withdraw from the facility. Again, as with the voluntary admission, a juvenile may only be committed and withdrawn by his parent.

The procedure for an involuntary commitment is set forth in Section 406 of the Act.[10] Briefly, this procedure allows a third party to petition the appropriate county court for the commitment of a person thought to be in need of care and treatment because of a mental disability. Persons for whom involuntary commitment is sought are provided with notice, hearing and the right to counsel.[11] The provisions of this section make no distinction as to age.

Finally, there is the emergency commitment.[12] In this situation a person who is observed as being dangerous to himself or others and in need of immediate care may be immediately taken into custody for the purpose of examination. Custody of the individual for the initial examination is accomplished without notice or a hearing, however, a commitment under this section of the Act may not exceed ten days. Again, there is no distinction as to age contained in the emergency commitment provisions of the Act.

Several other features of the Pennsylvania system of mental health admissions bear noting. First, any person committed to a mental health facility may test the va-

[10] 50 Pa. Stat. Ann. §4406 is set out in full at pp. 6-8, supra.

[11] 16 Pa. Stat. Ann. §9960.6(c) provides that counsel be appointed for any person who is unable to afford counsel and who is the subject of an involuntary commitment action.

[12] See Section 405 of the Act which is set out in full at pp. 4-6, supra.

lidity of his custody by petitioning for a writ of habeas corpus in state court. 50 Pa. Stat. Ann. §4426. Moreover, a patient may demand an independent psychiatric evaluation to assure the accuracy of the diagnosis by which he stands committed to the facility. 50 Pa. Stat. Ann. §4423-(7). Additionally, the director of any facility may discharge any patient when that patient no longer needs care and treatment in the facility. 50 Pa. Stat. Ann. §4418, §4420.

Finally, the Pennsylvania Department of Public Welfare promulgated regulations under the Act. These regulations augment sections 402 and 403 of the Act (voluntary admission, and voluntary commitment) as those sections apply to juveniles and are set forth at pp. 2-4 of this brief. Although the general effect of these regulations has already been highlighted, it is important to examine these provisions more closely at this point. Parts 2 and 3 of the regulation guarantee that no juvenile may be admitted to a Pennsylvania facility unless two independent psychiatric examinations concur that admission is appropriate. If the results of these examinations do not concur in the need for hospitalization, the child may not be admitted. Moreover, within 24 hours of admission, every child over 13 years of age must be given oral and written notice of his rights, including the right to receive periodic reports of his condition, the right to communicate with family and counsel, and, if necessary, the right to be furnished counsel.[13] If the juvenile objects to continued treatment in the institution, counsel is immediately notified, as are all other interested parties. At this point, the child's hospitalization may continue for a maximum of

[13] Section 5 of the Regulations at pp. 9-15, supra.



two business days during which appropriate proceedings must be commenced under Section 406 of the Act, or the child must be discharged.[14]

This, then is the general statutory and regulatory framework within which children may be admitted or committed to mental health facilities in Pennsylvania. It is indeed an understatement to note that there are legal impediments confronting parents intent on "dumping" a child in a Pennsylvania mental health facility. In fact, Pennsylvania compares very favorably with most of her sister states in this regard. Defendants' examination of similar state statutes reveals that Pennsylvania's pre- and post-commitment standards and procedures for juveniles far exceed those provided in most, if not all, of those states.[15]

[14] Section 6 of the Regulations at pp. 9-15, supra; there is a possibility of a slightly extended institutionalization in the situation where the director of the facility involved cannot locate the applicant (parent or guardian) and continued hospitalization is recommended. In this case the involuntary civil commitment is then instituted by the appropriate base service unit (local mental health referral and treatment agency).

[15] Statutes reviewed: Hawaii R. S. Sec. 334-52; Idaho Code Ann. Secs. 66-318, 66-320; Ky. R. S. Sec. 202.015; 34 M. R. S. A. (Maine) Secs. 2291, 2293; Md. Ann. Code, Art. 59, Sec. 11(g); Mass. G. L. A. Ch. 123, Secs. 10, 11; Mich. C. L. A. Sec. 303.19a; Minn. Stat. Ann. Sec. 253A 03 subdiv. 1 and 2; V. A. M. S. (Missouri) Secs. 202.783, 202.790; Mont. Rev. Codes Ann. Sec. 38-406.2; Nev. R. S., Sec. 433.665; N. H. R. S. A. Secs. 135:22, 135:-22-a; N. J. S. A. Secs. 30:4-46, 30:4-48; N. M. Stat. Ann. Secs. 34-2-2, 34-2-4(2); N. Y. Mental Hygiene Law Sec. 71; N. D. Century Code Secs. 25.03-01, 20-03-06(2); Ohio Rev. Code Ann. Secs. 5122.02, 5122.03(a)(2); 43 Okl. St. Ann. Sec. 184; O. R. S. (Oregon) Sec. 426.220; Pa. Stat. Ann. tit. 50, Secs. 4402, 4403; S. C. Code Sec. 32-951; Tenn. Code Ann. Sec. 33-601; Utah Code Ann.

## B. The Rights of Children in State Instituted Delinquency Proceedings Do Not Exist in This Case

1. Increased recognition of the legal rights of the mentally ill and mentally retarded [16] has in large part occurred as a result of litigation of relatively recent vintage.[17] Moreover, the majority of those cases dealt with securing various procedural rights for those who were, or were about to be institutionalized. In all of these cases the competing interests have been those of the patient or prospective patient and the state. And it has generally been found that the due process clause limits to some degree the power of the State to confine persons against their will for the sake of treatment. [18]

This case is different for it is not concerned with the power of the state *vis-a-vis* the individual. Here there is

Sec. 64-7-29; 18 V. S. A. (Vermont) Secs. 7503, 8001; Va. Code Ann. Sec. 37.1-65; R. C. W. A. (Washington) Secs. 72.23.-070, 72. 23.090; W. Va. Code Ann. Secs. 27-4-1, 27-4-3; W. S. A. (Wisc.) Sec. 51.10; Sec. 25.54, W. S. (Wyoming).

[16] Later criticism of the lower court's order in this case will demonstrate that the two groups, emotionally ill and mentally retarded, should have been treated separately. However, for the sake of brevity, both groups together will hereafter be referred to as "mentally ill".

[17] While there were early cases on the fringes of the controversy, see e.g. *In re Joseph* (sic) *Oakes,* 8 Law Rptr. 122 (Sup. Jud. Ct. Mass. 1845), as cited in J. Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions,* 62 Cal. L. R. 840, 841 (1974), the significant inroads in this area were not made until the mid and late sixties.

[18] See e.g. *Jackson v. Indiana,* 406 U.S. 715; *In Re Ballay,* 482 F. 2d 648 (D.C. Cir. 1973); *Dixon v. Attorney General of Pennsylvania,* 325 F. Supp. 966 (M.D. Pa. 1971).



a direct confrontation between the wishes of the child and his parent. Rather than state versus individual, in this case it is child versus parent. The voluntary admission of juveniles to a mental facility has been described as presenting a triangular configuration of competing interests, those of the parent, child and state. [19] And by this action the plaintiffs seek to severely diminish the parents' role in the decision to seek institutional care for their child.

The plaintiffs' theory is not complex: (a) unless one is free to leave an institution at will, one's hospitalization is not voluntary; (b) since children cannot come and go as they please against the wishes of their parents and physicians, they are involuntarily hospitalized; and (c) involuntary commitment in a mental hospital without a prior hearing and the right to counsel is a denial of liberty without due process of law. Their argument's simplicity amounts to little more than a "knee-jerk application of the [Fourteenth] Amendment" [20] which was unfortunately subscribed to almost *in toto* by the court below. As is the case with most simple solutions to complex issues, grave difficulties and serious questions have arisen which cause the need for a more probing analysis.

For instance, by the terms of the lower court's order there is absolutely no distinction made between the six month old severely retarded infant with brain damage and the seventeen year old emotionally disturbed youth. Moreover, the lower court by its order refused generally to distinguish between the mentally retarded and the emotion-

[19] Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions,* 62 Cal. L.R. 840, 877 (1974).

[20] *Ginsberg v. State of New York,* 390 U.S. 629, 648 (1968) (Mr. Justice Stewart concurring).

ally ill, and infants and teenagers, even though legal and practical considerations vary greatly for each group. [21]

2. In order to strike the proper balance between the interests of the parent and child, it is first necessary to briefly survey the contours of the Due Process Clause as it has been applied with respect to each. From this we will be able to determine whether the Due Process Clause limits the traditional role of the parent in the area of mental health where it does not in the provision of other recommended health services for his child. Moreover, this analysis will reveal that there is no basis for the finding below with respect to the child's due process rights in this area.

The rights of parents to direct the upbringing of their children has been given great deference in this Court. That is as it should be, for parents are presumed to act in the best interests of their children. Thus this Court noted in *Stanley v. Illinois,* 405 U.S. 645 (1972), at 651:

> The Court has frequently emphasized the importance of the family. The rights to conceive and to raise one's children have been deemed "essential," *Meyer v. Nebraska,* 262 U.S. 390, 399 (1923), "basic civil rights of man," *Skinner v. Oklahoma,* 316 U.S. 535, 541 (1942), and "[r]ights far more precious . . . than property rights," *May v. Anderson,* 345 U.S. 528, 533 (1953). "It is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder." *Prince v. Massachusetts,* 321 U.S. 158, 166 (1944). The integrity of the family unit has found protection in the Due Process Clause of the Fourteenth Amendment, *Meyer v. Nebraska,* supra, at 399, the Equal Protection Clause of the Fourteenth Amendment, *Skinner v. Oklahoma,* supra, at 541, and the Ninth Amendment, *Griswold v. Connecticut,* 381 U.S. 479, 496 (1965) (Goldberg, J., concurring).

[21] The special problems of the mentally retarded are specifically excluded from consideration in the discussion of this due process issue in *On the Voluntary Admission of Minors,* 8 Mich. J. of Law Reform, pp. 189, 192, n. 18 (Fall 1974). Also, see discussion of *Saville v. Treadway,* 404 F. Supp. 430 (M.D. Tenn. 1974), infra at p. 48 of this brief, which is a case similar to this. That court made broad exceptions in its order to accommodate the special needs of mentally retarded children.



The strength of these rights cannot be measured in a vacuum, however. For rights which are given a priority in one situation may be treated differently in another situation when competing interests are even more compelling. A review of those cases where parental authority over their offspring has been in issue makes clear that each case concerned attempts by a state in one way or another to intrude into this sphere of parental authority. In *Wisconsin v. Yoder,* 406 U.S. 205 (1971), this Court found that ". . . [the] primary role of the parents in the upbringing of their children . . ." *id.* at 232, predominated over the State's admittedly strong interest in compulsory public education, at least with respect to the last two years of required schooling. Similar results were reached in *Meyer v. Nebraska,* 262 U.S. 390 (1923), and *Pierce v. Society of Sisters,* 268 U.S. 510 (1925). By contrast in *Prince v. Commonwealth of Massachusetts,* 321 U.S. 158 (1944), the guardian's interest in that regard was not found to be superior to a state law forbidding street peddling of religious materials by children.

The rights parents enjoy in their children generally flow from their parental duties.[22] *Meyer v. Nebraska,* 262 U.S. 390, 400 (1922). Surely one of the highest duties of parenthood is protecting the health of one's children. This duty is certainly as important as the parental interest in directing the education of one's children. *Wisconsin v. Yoder,* 406 U.S. 205 (1972); *Pierce v. Society of Sisters,* supra; *Meyer v. Nebraska,* supra. So compelling is this duty that the state will not interfere with a parent's actions in this regard unless a life threatening situation has been created for the child by the parents' actions or inactions. *In Re Green,* 448 Pa. 338, 292 A.2d 387 (1972); *In Re Seiferth,* 309 N.Y. 80, 127 N.E. 2d 820 (1955); cf. *Bykofsky v. Middletown,* 401 F. Supp. 1242 (M.D. Pa. 1975). Similarly a state's interest in the education of its children, described by this Court as being "at the very apex of the functions of a State" is not paramount to the rights of parents to provide alternative education for their children. *Wisconsin v. Yoder,* supra at 213.

These parental rights are, of course, an essential element of a general familial right of privacy which has been given special recognition by this Court. Thus Mr. Justice Blackmun noted in *Roe v. Wade,* 410 U.S. 113 (1972):

> [The] decisions make it clear that only personal rights that can be deemed "fundamental" or "implicit in the concept of ordered liberty", *Palko v. Connecticut,* 302 U.S. 319, 325 (1937), are included in this guarantee of personal privacy. They also make

[22] Implicit in the recognition of parental duties is the power to perform those duties. Kleinfeld, "*Balance of Power Among Infants, Their Parents and the State*"; 4 Fam. L.Q. 410, 413 (Dec. 1970).



> it clear that the right has some extension to activities relating to marriage, *Loving v. Virginia,* 388 U.S. 1, 12 (1967); procreation, *Skinner v. Oklahoma,* 316 U.S. 535, 541-542 (1942); contraception, *Eisenstadt v. Baird,* 405 U.S. at 453-454; *id.* at 460, 463-465 (White, J., concurring in result); family relationships, *Prince v. Massachusetts,* 321 U.S. 158, 166 (1944); and child rearing and education; *Pierce v. Society of Sisters,* 268 U.S. 510, 535 (1925), *Meyer v. Nebraska,* supra. *Id.* at 152-3.

3. In this case the plaintiffs' parents sought psychiatric in-patient therapy at Haverford Hospital for their children. After a complete medical examination, each of the plaintiffs was admitted for treatment.[23] Subsequently, each child objected to this type of medical treatment and expressed those objections by this lawsuit.[24] However viewed, this case directly challenges the general right of parents to authorize medical care which has been medically recommended for their children against the child's wishes. This challenge to parental authority has been predicated on the child's asserted rights to due process of law.

Generally, the type of situation that will provide a sufficient basis for the state's intervention into the parent-child relationship involves an abdication of responsibility toward the child by the parent. Examples of this type of

[23] The testimony of Dr. Barbara Armstrong of Haverford State Hospital indicates that, in fact, each of the plaintiffs did receive a psychiatric examination prior to admission which was, and still is required by Sections 402 and 403 of the Act (109a).

[24] Under the regulations enacted shortly after this lawsuit was commenced each of the plaintiffs would be furnished counsel and provided a hearing to challenge their continued institutionalization. See pages 9-15, supra.

intervention by the State are child abuse proceedings, neglect proceedings and ultimately proceedings to terminate parental rights altogether. *Prince v. Massachusetts,* 321 U.S. 158, 166 (1943); *In Re Stuart,* 114 F.2d 825 (D.C. Cir. 1940). Also included in this category are situations where the parent is effectively foreclosed from assuming his traditional role of responsibility, such as in the area of public education, e.g. *Baker v. Owen,* 395 F. Supp. 294 (M.D.N.C. 1975); *Sims v. Waln,* 388 F. Supp. 543 (S.D.O. 1974) (involving State's power to discipline children in public schools); compare *Glasser v. Marietta,* 351 F. Supp. 555 (W.D.Pa. 1972).

This case presents a conflict between recognized rights of parents and due process rights claimed by their children.[25] The conflict is between the parent's power to authorize medical treatment for his child which has been recommended by a physician and the child's asserted right to refuse that treatment. By its decision, the lower court found that this parental authority was outweighed by these misperceived due process rights of the child.

4. In finding that these children have a personal right of liberty superior to their parent's right to provide recommended medical care, the court totally failed to consider the parental rights. The lower court's decision did not address the question of whether or not the parental duty to provide for their children's health and welfare, and concomitant right to follow legitimate medical advice in that regard, would be intolerably compromised by this massive intrusion of state regulation sought and ordered

[25] See *Wisconsin v. Yoder,* 406 U.S. 205 (1972), and *Heryford v. Parker,* 396 F. 2d 393 (10th Cir. 1968), which specifically did not reach this confrontation.



in this case. Rather the court focused only upon the child's interests without regard to the parental rights involved. The finding that the plaintiffs were entitled to due process of law rested not on an analysis of the child's relationship with his parent but rather upon a nonexistent adversary relationship with the state. Viewing the question from that perspective the finding of these rights for the children is not surprising, but is nonetheless erroneous.

First the court found that the *state's* interest in "the family unit, [and] maintaining the rights of parents to the custody, care, and upbringing of their children . . ." (792a) was not sufficient to override the due process mandates of the Fourteenth Amendment. The court went further and determined that defendant's assertion that the state is acting ". . . as *parens patriae* and not as an adversary" (794a) ". . . ignore[d] that the child [was] involuntarily removed from his home . . ." (794a). This reasoning ignores two factors central to the case. First, even if the *state's* interest in "maintaining the rights of parents" is not compelling—what of the *parents'* interest in their rights to provide for their children's health? *Roe v. Wade,* 410 U.S. 113 (1972). Perhaps more importantly, the court decided the case without ever addressing the real issue when it dismissed the defendants' arguments as ignoring that the child was involuntarily removed from his home.[26] The removal was only involuntary from the child's point of view—it was, after all, the children's parents who initiated the admission procedure not the state. While a child may have due process rights *vis-a-vis* the state in a delinquency proceeding, *In Re Gault,* 387 U.S. 1

[26] The second part of this argument will deal more fully with the question of the child's due process rights in this situation.

(1966), those rights are not controlling when the child's loss of freedom is the result of a joint decision between his parent and doctor. *Roe v. Wade,* supra.

Moreover, the court's conclusion that a parent may not waive the constitutional rights of his child in this regard misses the point (798a). Surely if the state were to institute delinquency proceedings against a child it is very doubtful that a parent could legally waive his child's due process rights in those proceedings. But that is not this case. Here the court found rights for the child in one setting—state versus child—and applied those rights in a wholly different setting—parent and doctor versus child. [27] When a parent, with a doctor's advice, places his child in a general hospital for long term care such as physical therapy and the child objects, surely no one would suggest that the child is "involuntarily" removed from his home in a legal sense. But this is a very different situation than when the state seeks to remove the child from his home for rehabilitation as the result of a delinquency finding, and the rights of the child in the latter situation cannot be assumed in the former. Surely the law must view the relationship between a parent and his child differently than it views the relationship between the state and that child.

5. Finally the opinion and order in this case creates a presumption of child abuse when a parent accepts the

[27] This transplantation of rights is clear from the fact that the lower court relied for its finding of a due process violation on cases such as *Dixon v. Attorney General of Commonwealth of Pennsylvania,* 325 F. Supp. 966 (M.D. Pa. 1971); *Lessard v. Schmidt,* 399 F. Supp. 1078, remanded 414 U.S. 473 (1974), redecided 379 F. Supp. 1376 (1974), remanded 421 U.S. 957 (1975), and *Lynch v. Baxley,* 386 F. Supp. 378 (M.D. Ala. 1974), all of which are state-versus-individual cases.



advice of two psychiatrists to seek institutional care for his child. The rather bizarre effect of this is that when a parent, however reluctantly, decides to seek and follow a doctor's advice recommending in-patient psychiatric care for his child, that parent must then *prove his case* against his child in a courtroom in order to secure the recommended treatment for the child. [28] These concerns were not addressed by the lower court because of its failure to perceive the case in its proper light. Due Process rights that exist in one situation are not necessarily transferrable to another. It is therefore necessary to view the plaintiffs' claim in the proper context: contrasted with the recognized right of parent to authorize medical treatment for his child, does the child have any rights to due process, and, if so, do they outweigh the rights of the parent?

## C. Admission or Commitment of a Child to a Mental Facility Does Not Require a Hearing

1. The Due Process rights of juveniles have been the subject of relatively recent decisions in this Court.

[28] While there is some disagreement over this point it seems quite reasonable to assume that a full adversary hearing as has been ordered in this case will not enhance the family situation. Most of the expert witnesses agreed that such a hearing would be traumatizing for the child and the family (566a, 636a, 655a, 687a, 689a-690a, 697a-699a, 727a). See generally, *Recognition and Protection of the Family's Interests in Child Abuse Proceedings,* 13 Fam. L.Q. 803 (1973-74). Certainly, all of these hearings will result in a diminution in the quality of services available inasmuch as the already limited resources of the mental health system will be severely taxed, *On The Voluntary Admission of Minors,* Univ. Mich. J. L. Ref. 189, 206 (Fall 1974).

However, these cases have all been attacks upon the procedures in delinquency proceedings instituted by the state rather than challenges to parental power. Nevertheless, the principle of overriding importance in these cases is applicable and enlightening here.

Juveniles' rights have been recognized by this Court in piecemeal fashion in a series of cases beginning in 1948 with *Haley v. Ohio,* 322 U.S. 596 (1948), and continuing through the decision rendered last year in *Breed v. Jones,* 421 U.S. 519 (1974). The clear trend of those decisions has been to require in juvenile proceedings carefully selected procedures, which procedures have been deemed essential to fundamental fairness in criminal proceedings for adults. *McKeiver v. Pennsylvania,* 403 U.S. 528 (1970). This has been a disquieting process, for the Court has continued to recognize the implications of a more formal criminal justice system for juveniles. Thus, this Court in *McKeiver v. Pennsylvania,* at 545 avoided a "remake [of] the juvenile proceeding into a fully adversary process . . .". Nevertheless, the harsh realities of the unfulfilled aspirations of the present system, *Breed v. Jones,* supra at 528, and the essentially criminal nature of juvenile proceedings, *In Re Gault,* supra at 36, 50, have necessitated these reforms.

This Court has accordingly required that juveniles be afforded the rights of notice, counsel, confrontation and cross-examination in delinquency proceedings. *In Re Gault,* supra. Moreover, proof of delinquency must not meet the traditional heavy burden of beyond a reasonable doubt. *In Re Winship,* 397 U.S. 358 (1970). Similarly, in *Haley v. Ohio,* 332 U S. 596 (1948), and in *Gallegos v. Colorado,* 370 U.S. 49 (1962), coercive procedures



used in obtaining confessions from juveniles were ruled unconstitutional. However, this Court has not required that all rights constitutionally guaranteed adults charged with a crime be made available to juveniles similarly accused. In *McKeiver v. Pennsylvania,* 403 U.S. 528, 533 (1970), the Sixth Amendment right to trial by jury was not imposed upon the juvenile justice system.

2. The consideration of overriding importance which is derived from these cases is abundantly clear.[29] Procedures required in the adult criminal process which go to the integrity of the fact-finding determination, the "was it done and did the defendant do it" determination, have been generally imposed on the juvenile justice system. Thus, confessions elicited under questionable circumstances, normally of dubious reliability, became even more unreliable when extracted from a child. *Haley,* supra; *Gallegos,* supra. It was noted in *Gault* that "[w]ith respect to juveniles, both common observation and expert opinion emphasize that the 'distrust of confessions made in certain situations' . . . is imperative in the case of children from an early age through adolescence." *Id.* at 48. Similarly, the process by which the facts are determined in connection with a defendant's guilt or innocence is extremely suspect, as is the reliability of those facts found, if the defendant is denied the right to effectively challenge those findings through confrontation and cross-examination, with counsel's assistance. *Gault,* supra. And in further application of this principle in *McKeiver* this Court

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[29] *Breed v. Jones,* 421 U.S. 519 (1975), and *Kent v. U.S.,* 383 U.S. 541 (1965), dealt with the procedures which ultimately determine if a juvenile will be tried as an adult which is obviously unique to the juvenile system with no counterpart in the traditional criminal process for adults.

concluded that "[t]he imposition of the jury trial on the juvenile court system would not strengthen greatly, if at all, the fact-finding function . . ." Thus, this Court held that the right to a jury trial was not required in a juvenile proceeding. *Id.* at 547.

3. Whether or not these types of fact-finding procedures are useful, of course, depends upon the types of facts sought to be determined and ultimately upon the overall purpose of that proceeding. Notwithstanding its label as a "civil proceeding", the determination in a delinquency proceeding is whether or not a particular youth has broken the law. *McKeiver v. Pennsylvania*, supra at 541. The question is "was it done" and, moreover, "did he do it?".

What then is the purpose of the juvenile commitment proceedings sought by the plaintiffs and ordered by the lower court in this case? The purpose is clearly not to determine "did he do it" as is the case in delinquency proceedings. Instead, the purpose should be to find out whether the child has a particular mental condition necessitating psychiatric in-patient therapy. This fact-finding process differs radically from that which is required in the delinquency proceeding.

The decision to institutionalize a child is medical in nature.[30] In Pennsylvania a child must be examined by at

[30] The plaintiffs will undoubtedly argue that voluntary commitments are really the result of a "did he do it" type of inquiry. However, in at least one study it was concluded that children were not hospitalized in order to sanction behavior which may be when a "did he do it" inquiry would apply, but rather for treatment of very serious mental conditions. Moreover, that study concluded that all treatment alternatives were explored before hospitalization was ordered. Rabinovitch, *Are Inpatient Hospital Services for Children Obsolete?*, 5 Michigan Mental Health Research Bulletin 3 (1971); see also Rabiner, Laurie, *The Case for Psychiatric Hospitalization*, 131 Am. J. Psychiatry 761 (July 1974).

Finally, the record in this case indicates that each patient was admitted on the basis of medical need and not as punishment for errant behavior. And in this regard the expert testimony of Dr. Derek Miller points out that psychiatrists and not lawyers and judges are best suited to define the medical needs of the patient (689a).



least two psychiatrists independently of each other, and both must agree on the need for in-patient institutional care before the child can be admitted to an institution. This inexorably leads to the conclusion that the critical "fact-finding" in the process is a medical diagnosis rather than an adjudication of guilt or innocence. If judicial evaluation of a recommended medical treatment plan is the underlying purpose for which the adversary proceeding ordered below is intended—and surely it is—then the timeless description of the juvenile court system rendered sixty years ago by Roscoe Pound will equally befit the courts that participate in this venture. After examining the system of juvenile justice Professor Pound found it to be ". . . an enterprise originally designed to use power and authority of law to achieve ends not amenable to legal means."[31]

With a medical diagnosis in the mental health area, the key findings are not whether a particular event actually occurred and whether a certain person "did it". Rather the key is a medical determination predicated upon pro-

[31] Lemert, E., Instead of Courts, Crime and Delinquency: *National Institute of Mental Health* at 5 (1971) citing Roscoe Pound, the "Limits of Effective Legal Action", Twenty-Second Annual Report of the Pa. Bar Association, XXII, 1916, pp. 221-239.

fessional observations of behavior. This may or may not involve some factual determinations.[32] But just as courts do not insist upon second-guessing a medical diagnosis in the area of physical medicine, courts should be equally loath to do so in the area of psychiatry. Factual determinations are a part of the diagnostic practice in physical medicine no less than is the case in psychiatry. Thus, when a mother brings her two year old child to a doctor and explains the child's symptoms—mental, physical or both—a court hearing to check the accuracy of the doctor's diagnosis and recommended treatment is unwise, unwarranted, and without precedent.

4. Two factors have been generally regarded as a basis for treating the psychiatric recommendation for institutional care different than all other medical treatment plans, physical or psychiatric: First, the tenativeness of psychiatric conclusions, and secondly the nature and consequences of some treatments such as long-term institutional care, along with the stigma of being diagnosed mentally ill.

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[32] These factual determinations in some cases may even involve the accuracy of reports of various conduct that could be classified as delinquent or criminal (790a). And this conduct, or even reports of this conduct, may have been the impetus for a child's parents to seek psychiatric help. But that is not to say that the child is hospitalized because of these reports, for manifestations of mental illness or retardation are sought and detected in many ways by those who possess the proper psychiatric training.

Thus the lower court's statement that children were institutionalized for truancy may be no more accurate than the statement that a person had heart surgery for chest pains—surely the chest pains brought the patient to the doctor and such a notation would undoubtedly appear on his admission note—but that of course is not the whole picture (See testimony of Dr. Tashjian at 650a-652a).



The relative uncertainty of diagnosis in the area of psychiatry, is often exaggerated and sensationalized.[33] This relative uncertainty, however pervasive, only serves to emphasize the questionable wisdom of having judges, completely untrained in the field of psychiatry, issuing diagnoses, prescribing treatment, or even choosing between two conflicting diagnoses which might be created by conflicting expert opinions. The questionable value, if not harm, of this type of judicial prescription of treatment is aptly demonstrated in a recent study where it was noted, after observing many commitment proceedings, that the independent fact-finder never disagreed with the psychiatric opinions and recommendations.[34]

It will of course be argued that plaintiffs are not really seeking a medical diagnosis from the courts, but rather they only seek to make it more difficult to institutionalize a child. And they will further urge that their aim

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[33] See Roth, L., M.D., *Some Comments on Labeling.* Bulletin of the American Academy of Psychiatry and the Law at 7-8 (in press) which strongly criticizes Rosenhan's, *On Being Sane in Insane Places*, 179 Science 250 (1973), which is generally offered as proof of the total uncertainty of psychiatric diagnosis. *O'Connor v. Donaldson*, 422 U.S. 563, 584 (1975) (Concurring Opinion, Chief Justice Burger), notes these persistent difficulties in the area of psychiatric medicine.

[34] Wengler & Fletcher, *The Effect of Legal Counsel on Admissions to a State Mental Hospital: A Confrontation of Professions*, 10 J. of Health & Social Behavior 66, 68 (1969). Moreover, Dr. Barbara Armstrong, a psychiatrist at Haverford State Hospital, testified that in her experience at Haverford she had seen only one real error in a medical diagnosis for institutional treatment, *and that followed a complete judicial hearing* (95a-96a). Most of the witnesses who testified in this proceeding agreed that interruption of the treatment process for the required hearing would be potentially harmful (95a-96a, 655a, 698a-699a, 543a-544a).

is to assure that other alternatives have been examined before commitment is ordered.[35] And finally, it is contended that a judicial hearing minimizes the possibility of a child being "railroaded" into an institution by ill-intentioned parents.[36] *Wengler and Fletcher*, supra, at 43, found that the presence of counsel at mental commitment proceedings increased the length of those proceedings and reduced the number of commitments. Thus, it is obvious that requiring a hearing and counsel will have an even greater effect along those lines. Studies have also shown that the more intervening evaluation procedures of any type that are required before admission generally result in a decreased institutionalization.[37] Those who would applaud that result, and there are no doubt some, would nonetheless misuse the judicial process to accomplish a social policy deemed by them to be desirable (de-institutionalization) through judicial rather than legislative means. The words of Professor Pound are well remembered at this point.

Undoubtedly, there are cases where parents have been successful in placing their child in an institution for the

[35] Dr. Henry Kandler, a psychiatrist and an expert witness for plaintiffs, felt that a hearing would make everyone "do a better job" and it may yield a "compromise" in treatment plans (543a-544a).

[36] Dr. Kandler testified that a hearing would militate against the "railroading" of a child into an institution by his parents (544a). This of course overlooks the required independent psychiatric examinations as well as the availability of habeas corpus and the present right to a hearing upon demand by a child over 13 years of age.

[37] Marsden, G., *Selection of Children for Residential Treatment: A Study of the Process*, 9 J. Am. Acad. Child Psychiatry, 332-46 (1970).



wrong motives. But is that the fault of the process or the parents? Assuming that the true motives of these unscrupulous parents would surface in a judicial hearing—what then? Surely the family relationship had long since broken down. Thus, the child's victory at the hearing is truly a pyrrhic one and the real problem has only been exacerbated.[38]

The second ground for urging that this type of an adversarial hearing is proper, notwithstanding the difficulties already alluded to, is the drastic consequences of institutional therapy.[39] Thus, the argument goes that because in-patient psychiatric therapy in an institution is accompanied by stigma and such a massive loss of liberty, all medical recommendations for such treatment must be scrutinized in a full adversary hearing. Likewise, the motives of the parent for concurring in this recommendation must also be judicially scrutinized, say the plaintiffs. First, the consequences of institutional treatment are surely less drastic than the course of treatment which was recommended in the celebrated case of *Matter of Quinlan*, 355 A.2d 647 (1976). Yet in that case the Supreme Court of New Jersey found that judicial second-guessing of that medical recommendation ". . . would generally be inappropriate, not only because that would be a gratuitous encroachment upon the medical profession's field of com-

[38] There can be little doubt that such an adversarial proceeding would only heighten the obvious intra-family hostilities in a situation where parents would abandon their children. *Recognition and Protection of the Family Interests in Child Abuse Proceedings*, 13 J. of Fam. Law 803 (1973-74).

[39] No one would advocate judicial scrutiny of the role of a psychiatrist in prescribing medicine or psychotherapy for his patient in an out-patient setting.

petence, but because it would be impossibly cumbersome." *Id.* 669. Without minimizing the consequences of institutional care, and without drawing undue conclusions from a case that is in all likelihood, *sui generis,* the New Jersey Supreme Court's unanimous refusal to require judicial scrutiny of a medical recommendation with those drastic consequences is instructive. Moreover, it should again be pointed out that, in deference to this concern Pennsylvania has a mechanism whereby a child over the age of thirteen can at any time question, with counsel the propriety of his continued hospitalization.

A variety of assumptions underlie the argument that the psychiatric recommendation of institutional care, albeit prompted by parental concern, should be reinforced by a full judicial hearing. First is the notion that all mental institutions are primarily warehouses for the unfortunate, and exist for society's convenience rather than for the treatment of the mentally ill. Although the record in this case contains absolutely no evidence of the conditions at any of Pennsylvania's institutions, there no doubt may be some institutions in this country which arguably fit that definition. But as a result of the great influx of additional public funds in this area[40] and because of a heightened social awareness of these problems, this type of institution is rapidly becoming a thing of the past. The inescapable fact of the matter is that there are mental illnesses in today's world requiring institutional care. Any deficiencies in those institutions should be remedied by legislative and executive action, not by injecting purpose-

[40] In Pennsylvania legislative appropriations for mental health and mental retardation have more than doubled in the past six years ($210,182,757—1970, Act of March 4, 1971, P.L. 809, No. 3-A; $445,632,000—1976, Act of June 4, 1976, P.L. , No. 7-A.)



less judicial proceedings into the treatment process where none is required. Moreover, while it is unfortunately true that society still has not completely shed its unenlightened attitudes toward these unfortunate citizens,[41] this alone is not a sufficient basis to pre-empt parental decision-making authority in this important area. Put quite simply, substantive changes in the health delivery system should not be attempted through the means of requiring inappropriate legal procedures in the treatment process.

On the strength of these assumptions—that a medical recommendation for institutional care is more akin to a finding of guilt than it is a prescription for treatment, and that any doctor's order for institutional care is uniquely suspect in validity because of the envisioned consequences of such treatment—the lower court ordered severe intrusions into the decision-making authority traditionally reserved to parent and doctor, *Roe v. Wade,* 410 U.S. 113 (1972), all in the name of due process. Beyond the fact that the decision of the lower court is predicated upon an erroneous extension of the Due Process Clause, the order intended to implement that decision is, by its sweeping nature, fraught with difficulties (833a-842a).

[41] Regarding the stigma that is assumed to exist as a result of institutionalization see MacMillan, *The Mentally Retarded Label: A Theoretical Analysis and Review of Research,* 79 American Journal of Mental Deficiency, 241 (1974), where it was noted that there is generally no real conclusive evidence in the scientific community on the effects of labeling the retarded. Moreover, in that same issue it was pointed out that labeling is really only a controversy with the marginally retarded as opposed to the more severely retarded. Id. at 253. See also, Rowitz, *A Sociological Perspective on Labeling,* 79 American Journal of Mental Deficiency, 265 (1974).

5. Notwithstanding the fact that most of the assumptions which give rise to the lower court's suspicion of medical and parental recommendations for institutional care apply even less to the severely retarded,[42] the order here applies to that group as well. In this connection the plaintiffs' own witness pointed out that most of his concerns regarding institutional care did not apply to the severely retarded (605a). Moreover, as has already been pointed out at n. 41 supra, the stigma effect of institutionalization is really not a concern for the severely retarded.

Beyond the generalized negative effects of the order appealed from, its application will for all practical purposes put an end to at least one very valuable program for the mentally retarded. In Pennsylvania, as in many other states there exists a program of respite care for families with retarded children (840a). This program allows families to institutionalize their retarded child for a specified time to allow them to take a vacation from the constant need for attention and care that such a disabled child requires.[43] Thus, the Court in *Saville v. Treadway,* 404 F. Supp. 430 (M.D. Tenn. 1974), while also erroneously finding Due Process rights for children in this situation, at least excepted respite admissions from its order.[44] *Id.* at p. 437.

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[42] In Pennsylvania approximately eighty percent of institutionalized juveniles are mentally retarded (310a et seq., current estimate D.P.W.).

[43] The lower court's reference to a family institutionalizing their child so they could take a vacation is misleading until it is realized that such short term commitments are actually encouraged as part of an overall program in Pennsylvania discouraging long term institutional care (790a).

[44] In *Saville v. Treadway,* 404 F. Supp. 430 at 437 (M.D. Tenn. 1974), a case similar to this case, also excepted the severely retarded from the requirement of a full judicial hearing.



Ironically the net effect of this could quite conceivably be an increase in the long term institutionalization of mentally retarded children.

Secondly, the order in this case makes absolutely no distinctions based upon the age of the children. To a one year old child the value of a lawyer, hearing and all of the other trappings of due process ordered in this case is very questionable. Be that as it may, and notwithstanding the expert testimony to the contrary, the lower court has required the defendants to ignore the realities and blindly treat the one year old exactly as the seventeen year old is treated. Again, in *Saville,* the court's order distinguished between children sixteen and over for whom a judicial hearing might be required and those younger than sixteen who would only be entitled to a hearing before what amounts to a professional panel.[45] *Saville v. Treadway,* supra, at 437.

6. Finally it should be noted that while the overall theories of *Saville* and the opinion in this case are similar in their errant reasoning, the process found due in *Saville* arguably does not even rise to the level of protection being provided in Pennsylvania and found to be unconstitutional by the lower court. Thus in *Saville* the error of assuming the legal similarity between a delinquency proceeding and a commitment proceeding was not

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[45] The testimony of Drs. Tashjian and Miller—defendants' expert psychiatrists—agree that the area of thirteen years of age is a good dividing line for psychologically distinguishing between children too young to responsibly assert their rights and those whose objections might very well be reliable (672a). Compare Pennsylvania's regulations which provide counsel and a hearing for children over the age of thirteen upon their objection to continued care in the institution.

exacerbated by requiring judicial second-guessing of psychiatric diagnoses and recommended therapy.[46]

7. Since the underlying principle of *Gault* and its predecessors—assuring the integrity of the fact-finding process—is not applicable in this case, an obvious question is raised. Has too much been proven? Do not the same reasons which have been advanced to demonstrate the inappropriateness of a judicial hearing in juvenile commitments also apply to adult proceedings?[47]

The reason the two positions are not contradictory is the same reason that underlies the fact that an adult may consent to, or refuse recommended medical treatment for himself and a juvenile cannot. In this country an element of freedom is the freedom of a competent adult to accept or reject health services *Winters v. Miller,* 446 F.2d 65 (2d Cir. 1971). Accordingly, it has been noted that none

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[46] Compare *J.L. & J.R. v. Parham,* F. Supp. , No. 75-163 M.A.C. (M.D. Ga. February 26, 1976); stay granted, *Parham v. J.L.,* 96 S. Ct. 1503 (1976).

[47] E.g., *Heryford v. Parker,* 396 F. 2d 393 (10th Cir. 1968); *In Re Ballay,* 482 F. 2d 648 (D.C. Cir. 1973); *Bell v. Wayne County,* 384 F. Supp. 1085 (E.D. Mich. 1974); *Lynch v. Baxley,* 386 F. Supp. 378 (M.D. Ala. 1974); *Dixon v. Attorney General of Pa.,* 325 F. Supp. 966 (M.D. Pa. 1971). Moreover, in *Specht v. Patterson,* 386 U.S. 605 (19 ), this Court noted that "[those] commitment proceedings whether denominated civil or criminal are subject both to the Equal Protection Clause of the Fourteenth Amendment as we held in *Baxtrom v. Herold,* 383 U.S. 107, and to the Due Process Clause." *Id.* at 608. Also note the concurring opinion of Mr. Chief Justice Burger in *O'Connor v. Donaldson,* at p. 580 where it is noted that ". . . involuntary commitment to a mental hospital, like involuntary confinement of an individual for any reason is a deprivation of liberty which the State cannot accomplish without due process of law."



of the states have laws which compel a physically ill individual to be involuntarily hospitalized solely because he needs treatment to protect his own welfare. *Developments In the Law: Civil Commitment of the Mentally Ill,* 87 Harv. L.R. 1190, 1216 n. 84 (1974). Moreover, no court has ever ordered a competent adult to accept such hospitalization and medical treatment solely for his own benefit. Compare *Application of President and Directors of Georgetown College,* 331 F.2d 1000 (D.C. Cir. 1964), with *Winters v. Miller,* supra. This freedom, like so many others, is unique to competent adults, and before it can be taken there must be due process of law.[48] Accordingly, an adult must be given a hearing before this freedom is involuntarily surrendered. The necessary counterpart to this freedom to refuse treatment is the power to authorize or consent to treatment. And as noted above, this power is also unique to adults. Eg. *Bonner v. Moran,* 126 F.2d 121, 75 U.S. App. D.C. 156 (1941). Similarly regulation of reading materials clearly protected by the First Amendment is permitted with respect to juveniles where such regulation would not be constitutionally permissible were it applied to adults. *Ginsberg v. New York,* 340 U.S. 629 (1969).

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[48] Some have raised the question of why mental illness is the only type of illness for which treatment is forcibly imposed, *Developments in the Law,* supra, at 1201-1228. The competence of the individual to refuse the treatment (the determination of which, it should be pointed out, *is* within the traditional adjudicatory role of courts) is surely paramount in the underlying rationale. See *Winters v. Miller,* supra. Be that as it may, and leaving aside the question of why competency is not the proper standard for commitment, it is sufficient to note that children have no claim to freedom to refuse needed and authorized medical care.

8. With all this in mind, we are confronted with the lower court's finding of a deprivation of due process in this case. Relying primarily on the rational of *Gault* the district court found a right that, as has been shown above, does not exist. That court read *Gault* and its progeny to require a hearing in this case to "enhance the possibility that truth will emerge from the confrontations of opposing versions and conflicting data" (793a-794a), quoting *In Re Gault*, supra, at 21. But in *Gault* this Court was trying to make a hearing procedure, essentially criminal in its purpose and effect, more fair to the accused. Here however, the court is *creating the hearing* to assure what it conceives to be a more socially acceptable medical diagnosis and mode of treatment. *Gault* never intended such a result. Medical treatment cannot be prescribed on the basis of one lawyer's presentation or another's cross-examination. This Court should heed the words of Professor Pound and not create an ". . . enterprise . . . designed to use the power and authority of law to achieve ends not amenable to legal means". Accordingly this Court should reverse the decision of the lower court.

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## II. The Order in This Case Violates the Eleventh Amendment and Alternatively, Violates the Rule of Preiser v. Rodriguez[49]

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A. 1. The lower court, concluding that children were entitled to due process protections prior to hospitalization in a mental facility, ordered a full complement of

[49] This argument is made in the alternative and assumes that plaintiffs prevail on the merits of the case.



procedural protections.[50] In addition to this prospective injunctive relief the Court also ordered that children presently being treated in any of the state's mental facilities be discharged, released or recommited pursuant to the newly ordered procedures within four months.[51] The validity of this portion of the lower court's order is questioned here.

2. The Eleventh Amendment[52] was proposed and ratified in the wake of this Court's opinion in *Chisholm v. Georgia*, 2 Dal. 419 (1793) which held that the State of Georgia was not immune from a contract action in federal court by a citizen of another state. There were generally two reasons for this Amendment. First the states were fearful that they would become fiscally unsound and unstable if their creditors' could sue and obtain judgments against them in the federal courts. Secondly, the notion of federal courts having this type of broad jurisdiction was contrary to commonly held beliefs of the states' sovereignty.[53]

Since its ratification two years after *Chisholm* there have been a variety of interpretations of the Eleventh Amendment "and the difference between the type of relief barred by the Eleventh Amendment and that permitted by *Ex Parte Young* will not in many instances be that be-

[50] This order is fully set forth at 843a-852a of the appendix.

[51] See paragraph 15E of the final order at 851a-852a.

[52] The Eleventh Amendment provides: "The judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by Citizens of another State, or by Citizens or Subjects of any Foreign State."

[53] *Attorneys' Fees and the Eleventh Amendment*, 88 Harv. L. R. 1875, 1877-78 (June 1975).

tween day and night". *Edelman v. Jordan,* 415 U.S. 651, 667 (1973). The Court's decision in *Ex Parte Young,* 209 U.S. 123 (1908), marks a significant development in this area. In that decision it was held that the Eleventh Amendment did not preclude injunctive actions against state officials. There the Attorney General of Minnesota relied upon the Eleventh Amendment and ignored an injunction restraining him from enforcing certain criminal statutes that were allegedly unconstitutional. In sustaining the lower court's jurisdiction and contempt citation, the Court held:

> If the act which the state Attorney General seeks to enforce be a violation of the Federal Constitution, the officer, in proceeding under such enactment, comes into conflict with the superior authority of that Constitution, and be in that case stripped of his official or representative character and is subjected in his person to the consequences of his individual conduct. The State has no power to impart to him any immunity from responsibility to the supreme authority of the United States. 209 U.S. at 159-60.

3. The principle of *Ex Parte Young* has undergone some refinements[54] culminating in the decision of this Court

[54] *Larson v. Domestic & Foreign Corp.*, 337 U.S. 682 (1948), held that an injunctive action brought against a state officer is barred if the action of the officer is not alleged to be either unconstitutional or beyond his statutory authority. Even then if the relief requested would require "affirmative action by the sovereign or the disposition of unquestionably sovereign property" the action ". . . may fail, as one against the sovereign." Id. at 691, n. 11. See generally, Mahon, M., *The Eleventh Amendment and Retroactive Welfare Benefits,* 36 U. of Pitt. L. R. 78, 91, n. 55 (Fall, 1974), for other cases dealing with the Eleventh



in *Edelman v. Jordan,* 415 U.S. 651 (1974). And it is the proper construction of that opinion that will ultimately resolve the present issue. In *Edelman* the plaintiffs alleged that certain of Illinois' public welfare regulations violated federal law and resulted in undue delay in eligible applicants' receipt of benefits. After finding the State's regulations to be in violation of federal law the District Court prospectively enjoined use of the regulations. In addition the trial court ordered that the defendant state officials "release and remit . . . benefits wrongfully withheld" during the period in question. *Edelman,* supra, at 656. It was this retroactive relief that the Court found offensive to the Eleventh Amendment. And, defendants contend that the same principles which formed the basis of that conclusion in *Edelman* exist any apply in this case.

This Court in *Edelman* found two aspects of that retroactive relief offensive to the Eleventh Amendment. First it was noted that the funds to satisfy the award would inevitably come from the general revenues of the state rather than from the individual defendants. *Edelman* supra, at 664-665. And secondly, it was noted that the fiscal impact of this award was not merely ancillary to, and the necessary result of ". . . compliance with [a] decree which by [its] terms was prospective in nature." *Id.* at 668. After noting these characteristics of the retroactive aspects of the relief this Court held that ". . . a federal court's remedial power, consistent with the Eleventh Amendment, is necessarily limited to *prospective injunctive relief* (cite omitted) and may not include a retroactive

Amendment barring relief of an affirmative nature. Affirmative action on the part of the defendants was definitely ordered in this case.

award which requires the payment of funds from the state treasury." *Edelman,* at 677 (emphasis added).

As in the *Edelman* case there can be little doubt that compliance with the retroactive order in this case will require substantial sums of public funds, and will severely disrupt the fiscal structure of the state in this area.[55] Moreover it is obvious that the state treasury will be the source of the moneys to carry out this order.

In *Edelman* the order of the court was both retroactive[56] and injunctive as is the case here. It is true, of course, that in *Edelman* the defendants were retroactively required to provide monetary benefits wrongfully withheld whereas in this case the defendants were retroactively required to provide procedural safeguards to those who had previously not received them.

[55] *Edelman,* supra, *id.* at 666, n. 11, reflects this Court's concern for the disruptive effects of awards of retroactive relief:

> It is not necessarily true that "[w]hether the decree is prospective only or requires payments for the weeks or months wrongfully skipped over by the state officials, the nature of the impact on the state treasury is precisely the same." *Post* at 682. This argument neglects the fact that where the State has a definable allocation to be used in the payment of public aid benefits, and pursues a certain course of action such as the processing of applications within certain time periods as did Illinois here, the subsequent ordering by a federal court of retroactive payments to correct delays in such processing will invariably mean there is less money available for payments for the continuing obligations of the public aid system.

[56] Any arguments that Paragraph 15E of the order below is somehow not retroactive can also be made with respect to the order in *Edelman.* Thus it has been argued in commenting in *Edelman* that "the federally-imposed retroactive payments [c]ould be seen as an ancillary effect of the prospective order to the officer to conform his conduct to federal law." The same strained assertion could and probably will be made in this case—that the fiscal impact of the requirements for those children already committed is only ancillary to a prospective order.



The question then becomes whether a retroactive injunction against a state violates the Eleventh Amendment only if it involves specific monetary relief. Such a narrow holding would ignore the bases for the Eleventh Amendment. First, most state programs involve the dispensation of services rather than funds to the public, and if this distinction is to control then the bulk of state governmental activity would be completely vulnerable to this type of severe disruption as a result of sweeping retroactive injunctions issued by a federal court.[57] Secondly and more importantly the disruptive effects, fiscally and governmentally, of broad retroactive injunctive relief is no less drastic than a straight monetary award.[58] *Attorneys' Fees and the Eleventh Amendment,* 88 Harv. L.R. 1875, 1880, n. 36 (June, 1975). In many cases such relief would be more disruptive than a "lump sum" damage award. No better example of this can be found than the instant case.

Moreover the principle of *Ex Parte Young* is not forsaken by reversing this portion of the lower court's

[57] The lower court also gave the state the "alternative" to release or discharge all of the children and cease all voluntary admissions. This is no alternative for to do so would be nothing short of total abdication of the Commonwealth's responsibilities to those children and their families.

[58] If this type of retroactive relief is permitted to stand then in a successful suit, for example in the medicaid area, the state could then be ordered to approve services retroactively regardless of the plaintiffs' current eligibility for those services. This type of relief is essentially the same as that ordered here and its obvious disruptive effects need not be elaborated upon.

order. Clearly if the plaintiffs' theory of constitutional law is correct in this case then the prospective injunctive award entered by the lower court completely assures the supremacy of that law in Pennsylvania. Cf. *Linkletter v. Walker*, 381 U.S. 618, 625 (1965). But what such prospective relief does not do is require the state to expend vast amounts of finite resources to provide certain procedural rights retroactively, regardless of the actual desires of the child involved.[59] Whatever the lower court's rationale[60] for such an order it runs afoul of the Eleventh Amendment.

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[59] As will be discussed more fully in the next section every child hospitalized in a Pennsylvania mental facility *always* has the right to contest the validity of his confinement by way of habeas corpus, and as noted previously, children over thirteen years of age need only object to their continued hospitalization and they will be provided counsel and a hearing. See 9-15, supra.

[60] In view of the lower court's heavy reliance on *In Re Gault* for its conclusion that the due process clause applied in this case, it is probable that the retroactive relief was premised upon a theory of retroactivity drawn from the area of criminal law. This Court has pointed out that where the primary purpose or effect of a new constitutional doctrine is to rectify the truth-finding function and the accuracy of the guilt determination it will be applied retroactively. *Williams v. United States*, 401 U.S. 646, 653 (1970). There are two problems with this approach here, first the medical determination of need for hospitalization is not an adjudication of guilt and therefore is not likely to be affected by new procedural rights. Secondly the medical determination is *always* open to appropriate scrutiny as opposed to a finding of guilt in a criminal case. See generally, Argument I(B), supra. See also, *Lemon v. Kurtzman II*, 411 U.S. 192 (1973) where this court declined to give retroactive effect to its earlier decision declaring a state law unconstitutional. This Court emphasized that "the effect of a given constitutional ruling on prior conduct is subject to no set



## B. The Retroactive Aspects of the Lower Court's Order Violates the Principle of Preiser v. Rodriguez

1. Any person, regardless of age, has a specific statutory right to petition for a writ of habeas corpus to test the validity of his confinement in a mental facility in Pennsylvania.[61] 50 Pa. Stat. Ann. §4426, supra at pp. 8-9. The plaintiffs in this case chose not to utilize this remedy but rather elected to institute this federal action under 42 U.S.C. §1983. The single issue in this regard is whether this was proper under the principle laid down by this Court in *Preiser v. Rodriguez*, 411 U.S. 475 (1973), or whether the plaintiffs were required to pursue their state remedy. It is defendants' position that while plaintiffs' claims for prospective injunctive relief may have been appropriate in a §1983 action *Gerstein v. Pugh*, 420 U.S. 103, 107, n. 6 (1974), their request for a retroactive injunction to apply to children then hospitalized was improper and the court's order to that effect should be reversed. See e.g. *Kendall v. True*, 391 F. Supp. 413 (W.D. Ky. 1975).

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principle of absolute retroactive invalidity . . ." *Id.* at 198-199. The Court further stated that this modern approach to the question was applicable in both civil and criminal contexts.

[61] If the plaintiffs were required to utilize the remedy of habeas corpus then 28 U.S.C. §2254(B), requiring exhaustion of state remedies, would apply. That section provides as follows:

> An application for a writ of habeas corpus in behalf of a person in custody pursuant to the judgment of a State court shall not be granted unless it appears that the applicant has exhausted the remedies available in the courts of the State, or that there is either an absence of available State corrective process or the existence of circumstances rendering such process ineffective to protect the rights of the prisoner.

In *Preiser* several state prisoners brought a §1983 action alleging that they were unconstitutionally deprived of good conduct-time credits. They sought injunctive relief to compel the restoration of these credits which would have resulted in their release from prison. After noting various examples where habeas corpus was the appropriate remedy the Court noted that "in each case [the petitioner's] grievance is that he is being unlawfully subjected to physical restraint . . ." Id. at 486.

Since it was clear that the plaintiffs' complaint in *Preiser* challenged the legality of their physical restraint, Id. at 487, the only remaining determination was whether or not habeas corpus was the *exclusive* remedy by which they could proceed. This Court held that it was, and that therefore the plaintiffs' §1983 claims were barred for failure to exhaust their state remedies.

2. The federal exhaustion requirements apply to all cases where habeas corpus is an appropriate remedy. Thus section 2254(b) merely refers to ". . . a person in custody pursuant to the judgment of a state court." This clearly includes mental patients. Moreover, the fact that the plaintiffs in this case were technically not in custody "pursuant to the judgment of a State court" does not render the exhaustion requirement inapplicable. In *Preiser* this Court rejected a similar contention noting that an attack upon a state's administrative procedures by one seeking release is no less within the "core of habeas corpus" than an attack upon a prisoner's conviction ". . . for it goes directly to the constitutionality of his physical confinement itself . . . ." Id. at 489. Moreover habeas corpus was available to the plaintiffs in this case and in fact, would have been a complete remedy. E.g. *Heryford v. Parker,* 396 F.2d 313 (10th Cir. 1968); *Hartmann v. Scott,* 488 F.2d 1215 (8th Cir. 1973).



The plaintiffs in this case were attacking the legality of their confinement. The complaint sought to enjoin the continued enforcement of the sole statute from which the defendants derived their authority to confine the plaintiffs (22a-23a). Moreover their claims were predicated upon their expressed desire to be released from confinement 12a, 14a-16a).[62] The plaintiffs were not challenging the conditions of their confinement, *Preiser,* supra at 498, nor did they seek damages.[63]

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[62] Compare *Gerstein v. Pugh,* supra at 106, 107, n.6, where the plaintiffs did not seek release from custody and, perhaps more importantly, the state law specifically precluded the use of habeas corpus to challenge that type of confinement.

[63] The complaint in this matter did originally request damages, however that claim was dropped midway in the litigation (23a). Even if the damage claim had not been abandoned this Court's holding in *Wolff v. McDonnell,* 418 U.S. 539 (1973), would also render the retroactive portions of the lower court's order invalid. In *Wolff* the Court noted that since damage claims were not available within a habeas corpus action, a prisoner's claim for damages was properly maintained under §1983 even if the determination of that claim required ancillary determination of claims that, standing alone, would be required to be brought by way of habeas corpus. The Court's opinion in *Wolff* makes it quite clear that any injunctive relief granted as a result of such an ancillary consideration must be prospective only, thus at 554-5 this Court held:

> The complaint in this case sought restoration of good-time credits, and the Court of Appeals correctly held this relief foreclosed under *Preiser.* But the complaint also sought damages; and *Preiser* expressly contemplated that claims properly brought under §1983 could go forward while actual restoration of good-time credits is sought in state proceedings. 411

The primary purpose for requiring exhaustion of state remedies is the concept of federal-state comity which is fundamental to "Our Federalism." *Younger v. Harris,* 401 U.S. 37, 44 (1971); *Preiser,* supra at 491. The lower court's order in this case ignored that principle by requiring complete retroactive application of its order.

3. Quite apart from the considerations of *Preiser,* without any constitutional necessity therefore, and without ever making the Pennsylvania judicial system a party to this action, the lower court ordered that the Pennsylvania Court system conduct the several thousand hearings necessitated by its retroactive order (838a-839a).

There can be no question that such a massive imposition upon the Pennsylvania Judicial System will cause a clash between the federal and state judicial systems.[64]

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U.S., at 499, n. 14. Respondent's damages claim was therefore properly before the District Court and required determination of the validity of the procedures employed for imposing sanctions, including loss of good time, for flagrant or serious misconduct. Such a declaratory judgment as a predicate to a damages award would not be barred by *Preiser*; and because under that case only an injunction restoring good time improperly taken is foreclosed, neither would it preclude a litigant with standing from obtaining by way of ancillary relief an otherwise proper injunction *enjoining the prospective enforcement* of invalid prison regulations. (Emphasis added.)

[64] The Supreme Court of Pennsylvania, though not a party to this action, was so adversely affected by the retroactive aspects of the order in this case that the Chief Justice of the Pennsylvania Judicial System joined defendants' request for a stay of that order by telegram to each member of this Court. Moreover, the Supreme Court of Pennsylvania is presently seeking to leave to participate as *amicus curiae* in these proceedings to vindicate the state judiciary's interests in this matter. Fortunately the requested stay was granted by this Court. This has temporarily alleviated the undesirable result which could have arisen had the Pennsylvania Supreme Court—a non party—refused to so drastically disrupt its allocation of judicial resources to gratuitously accommodate this order.



Such a clash can only be justified in limited cases. State law and procedure must obviously conform to the requirements of the Constitution, *Miranda v. Arizona,* 384 U.S. 436 (1966). But in this case the lower court did not find that the constitution required a *judicial* hearing but rather that it required only a "hearing before an unbiased tribunal" (801a). A second possible justification for creating such friction between the two systems of government is equally inapplicable. Since no federal statutes are involved here this order was certainly not required by the Supremacy Clause. Thus it was clearly inappropriate for the lower court to order such a massive imposition upon the Commonwealth's Judicial System absent a basis founded upon a substantive constitutional violation. *Rizzo v. Goode,* 423 U.S. 362 (1975). Cf. *Lemon v. Kurtzman II,* 411 U.S. 192 (1973).

## CONCLUSION

On the basis of the arguments and authorities contained in Argument I, defendants seek reversal of the decision of the lower court. In the alternative, defendants request that this Court vacate those portions of the lower court's order which require retroactive application for the reasons advanced in Argument II.

Respectfully submitted,
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IN THE SUPREME COURT OF THE UNITED STATES

No. 75-1064

Jack B. Kremens, et al.,
*Appellants*
v.
Kevin Bartley, et al.,
*Appellees*

## CERTIFICATION OF SERVICE

And Now, this 7th day of June, I, Norman J. Watkins, Deputy Attorney General for the Commonwealth of Pennsylvania, Counsel for Appellants, hereby certify that on June 7, 1976, I served the Brief for Appellants by placing one typed copy of that document in the United States Mail, postage prepaid, in Harrisburg, Pennsylvania, addressed to David Ferleger, Esquire, 1315 Walnut Street, Philadelphia, Pennsylvania, 19107. I further certify that I served all parties required to be served.

NORMAN J. WATKINS
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Supreme Court, U. S.
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IN THE

# Supreme Court of the United States

OCTOBER TERM, 1976

No. 75-1064

JACK B. KREMENS, et al.,

*Appellants,*

v.

KEVIN BARTLEY, et al.,

*Appellees.*

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

## BRIEF FOR APPELLEES

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IN THE

# Supreme Court of the United States

OCTOBER TERM, 1976

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**No. 75-1064**

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JACK B. KREMENS, etc., et al.,

*Appellants,*

v.

KEVIN BARTLEY, et al.,

*Appellees.*

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ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

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## BRIEF FOR APPELLEES

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## QUESTIONS PRESENTED

1. Does the involuntary indeterminate mental institutionalization of juveniles by the state, without notice, counsel, hearing or other protections but upon parental application, violate the requirements of the Due Process Clause of the Fourteenth Amendment?

2. Did the District Court abuse its discretion in requiring the defendant state officials to assure that juveniles, presently committed, receive constitutional state procedures to determine whether they are mentally disabled and in need of institutionalization?

3. Does the District Court's requirement of constitutional state procedures to continue the confinement of juveniles unconstitutionally committed violate the Eleventh Amendment to the Constitution of the United States?

## STATUTES INVOLVED

In addition to the statutes reproduced by appellants, the following statutes were enacted by Pennsylvania on July 9, 1976.

### Mental Health Procedures Act
### Act No. 143

*Section 103. Scope of Act.*—This act establishes rights and procedures for all involuntary treatment of mentally ill persons, whether inpatient or outpatient, and for all voluntary inpatient treatment of mentally ill persons. "Inpatient treatment" shall include all treatment that requires full or part-time residence in a facility. For the purpose of this act, a "facility" means any mental health establishment, hospital, clinic, institution, center, day care center, base service unit, community mental health center, or part thereof, that provides for the diagnosis, treatment, care or rehabilitation of mentally ill persons, whether as outpatients or inpatients.

*Section 201. Persons Who May Authorize Voluntary Treatment.*—Any person 14 years of age or over who believes that he is in need of treatment and substantially understands the nature of voluntary



commitment may submit himself to examination and treatment under this act, provided that the decision to do so is made voluntarily. A parent, guardian, or person standing in loco parentis to a child less than 14 years of age may subject such child to examination and treatment under this act, and in so doing shall be deemed to be acting for the child. Except as otherwise authorized in this act, all of the provisions of this act governing examination and treatment shall apply.

*Section 202. To Whom Application May be Made.*—Application for voluntary examination and treatment shall be made to an approved facility or to the county administrator, veterans administration or other agency of the United States operating a facility for the care and treatment of mental illness. When application is made to the county administrator, he shall designate the approved facility for examination and for such treatment as may be appropriate.

*Section 204. Notice to Parents.*—the director of the facility shall promptly notify the minor's parents, guardian, or person standing in loco parentis, and shall inform them of the right to be heard upon the filing of an objection. Whenever such objection is filed, a hearing shall be held within 72 hours by a judge or mental health review officer, who shall determine whether or not the voluntary treatment is in the best interest of the minor.

*Section 206. Withdrawal from Voluntary Inpatient Treatment.*—(a) A person in voluntary inpatient treatment may withdraw at any time by giving written notice unless, as stated in section 203, he has agreed in writing at the time of his admission that his release can be delayed following such notice for a period to be specified in the agreement, provided that such period shall not exceed 72 hours.

(b) If the person is under the age of 14, his parent, legal guardian, or person standing in loco parentis may effect his release. If any responsible party believes that it would be in the best interest of a person under 14 years of age in voluntary treatment to be withdrawn therefrom or afforded treatment constituting a less restrictive alternative, such party may file a petition in the Juvenile Division of the court of common pleas for the county in which the person under 14 years of age resides, requesting a withdrawal from or modification of treatment. The court shall promptly appoint an attorney for such minor person and schedule a hearing to determine what inpatient treatment, if any, is in the minor's best interest. The hearing shall be held within ten days of receipt of the petition, unless continued upon the request of the attorney for such minor. The hearing shall be conducted in accordance with the rules governing other Juvenile Court proceedings.

(c) Nothing in the act shall be construed to require a facility to continue inpatient treatment where the director of the facility determines such treatment is not medically indicated. Any dispute between a facility and a county administrator as to the medical necessity for voluntary inpatient treatment of a person shall be decided by the Commissioner of Mental Health or his designate.

*Section 501. Effective Date and Applicability.*—This act shall take effect 60 days after its enactment and shall thereupon apply immediately to all persons receiving voluntary treatment. As to all persons who were made subject to involuntary treatment prior to the effective date, it shall become applicable 180 days thereafter.



*Section 502. Repeals.*—(a) The definition of "mental disability" in section 102, and sections 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 416, 418, 419, 420 and 426, act of October 20, 1966 (3rd Sp. Sess., P.L. 96, No. 6), known as the "Mental Health and Mental Retardation Act of 1966," are hereby repealed, except in so far as they relate to mental retardation or to persons who are mentally retarded. * * *

*Section 503. Severability.*—If any provision of this act including, but not limited to, any provision relating to children or the application thereof including but not limited to an application thereof to a child is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provisions or application and to this end of the provisions of this act are declared severable.

## STATEMENT OF THE CASE

On November 16, 1972, plaintiffs filed this class action against state officials[1] challenging those portions

[1] The defendants included the Secretary of the Department of Public Welfare of the Commonwealth of Pennsylvania which "has the power and duty to enforce" the state mental health law, to "make all regulations necessary and appropriate," and to "operate and assign functions to all state facilities." and the Deputy Secretary for Mental Health and Mental Retardation (277a). The superintendent of Haverford State Hospital, who is responsible for receiving applications for admission, commitment and release under the challenged statutes, was "sued as representative of the directors of all mental health facilities in Pennsylvania," all of which are under the authority of the defendants Secretary and Deputy Secretary (275a). In Pennsylvania, all mental institutions, public and private, are facilities subject to the statute and regulations. 50 P.S. §4102. Department of Public Welfare Regulations, Title 9100 (291a).

of Pennsylvania mental health statutes which permit the state to detain persons eighteen years of age or younger in mental institutions without substantial procedural protections including, *inter alia*, notice, counsel and opportunity for hearing. "In essence, plaintiffs claim that the present procedures do not adequately assure against the mistaken commitment of children who are not mentally ill." 786a - 787a; District Court Opinion, 402 F. Supp. at 1042 - 1043.[2]

A three-judge court was convened pursuant to 28 U.S.C. §§2281, 2284, and, prior to trial, extensive factual stipulations were entered into. At a three day hearing before the three judges, the testimony of six expert psychiatrists was heard. The depositions of three other psychiatrists were entered into evidence.

The class on whose behalf this action is maintained [3] includes "children who allegedly are mentally ill as well

[2]For convenience, all references to the District Court's reported opinion include the official citation thereof, 402 F. Supp. 1039 (E.D. Pa. 1975), in addition to reference to the Appendix.

[3]The defendants agreed to the District Court's suggestion that a guardian ad litem be appointed for the plaintiffs pursuant to Rule 17(c) of the Federal Rules of Civil Procedure: "With regard to the technicality involved, I am really at the courts' pleasure. I really do not object to the going through with Mr. Ferleger as a next friend." (250a). Thus, the issue suggested in an amicus brief of whether juveniles can ever initiate litigation by a next friend or guardian ad litem is not raised in this case. Brief of Michigan Association for Emotionally Disturbed Children *amicus curiae*. Regardless, federal courts have uniformly exercised their power under Rule 17(c) to protect minor litigants' interests where potential for parent-child conflict was present. *E. g., Roberts v. Ohio Casualty Insurance Co.*, 256 F.2d 35 (5th Cir. 1958).

The law in Michigan is equally clear and adverse to the *amicus* which fails to cite the leading case of *Buckholz v. Leveille* 194 N.W.2d 427 (Mich. 1975).



as children who allegedly are mentally retarded" (783a), 402 F. Supp. at 1041, n.1, who "have been, are, or may be admitted or committed to mental health facilities in Pennsylvania under the Pennsylvania Mental Health and Mental Retardation Act (Act)" (783a-784a).[4]

*Named Plaintiffs*

The named plaintiffs were five of the twenty-four juvenile retarded and mentally ill patients confined at Haverford State Hospital under the challenged statutes at the time the action was commenced (133a-134a).[5] They were confined after a psychiatric examination which lasted "anywhere from an hour to three quarters of an hour" (47a) "or shorter." *Id.* The reasons for admission of these persons (as stated by the hospital) were varied and included truancy, incorrigibility, homicidal and suicidal behavior, chaotic family, talking incoherently, rebellion, aggressive behavior, threats and assaults to family members, temper tantrums, sexual acting out, foul language, drug use and hallucinations (135a-165a). Treatment for the group included drugs, individual, group and family therapies, confinement to closed locked units, schooling, and confinement in seclusion rooms. *Id.*

[4]This inclusive class definition was uncontested by the defendants although they now undertake to criticize it. Brief for Appellants at 28, n. 16, 48; (275a).

[5]Eight additional juveniles were confined there under other sections of the law (133a - 134a). Children are held as civil "voluntary patients in the same treatment unit as those on criminal commitments." See Deposition of Dr. Barbara Armstrong (38a et seq., 135a - 165a).

At least ten of the juveniles were recorded as having objected to institutionalization at the time of admission; seven more objected after admission (122a-124a).[6] One "preferred to come rather than go to jail" (122a).

A summary of the commitment experiences of each of the named plaintiffs illustrates the fact patterns common to the class.[7]

Plaintiff K. B. was, and still is, critical of the hospital and believes that some of the hospital's regulations are arbitrary, that the staff played favorites with patients, that unnecessary punishments were imposed for minor rule infractions, and that patients were transferred to locked wards as punishment for mere allegations of wrong doing (277a-278a).[8] K. B. was diagnosed as a person with "Organic Brain Syndrome with epilepsy" and an "explosive personality." The hospital had some difficulty in its "efforts to work with his mother to allow her to become more receptive to his return to his home and community" (180a).

Electro-convulsive treatment (E. C. T.) was administered to plaintiff S. G. who was confined due to "his having become violent and aggressive towards his family and younger children in his neighborhood." He also received "high dosages of medication". Despite 61

[6]Juveniles whom the hospital psychiatrist considered "incompetent" to intelligently voice an objection are not included (122a - 124a). A number of these persons were deemed retarded.

[7]The statements are taken from either the parties' factual stipulations or hospital-prepared narrative summaries. See 166a *et seq.*

[8]Defendants admit that K. B. was critical as described but deny the validity of his beliefs (278a).



therapy sessions spaced over 15 months, his improvement was only marginal (172a-173a).

Plaintiff L. L.'s parents are divorced; her father is remarried and living in Florida; she would have (at the time of her commitment and the time this action was filed) liked to have been with her father because she gets along well with him. Every time she visits with her father, her behavior is excellent. L. L.'s difficulties in relating to her mother resulted in her commitment. Hospital records indicate Levine threatened the lives of her mother and sister and that she has a "personality disorder." (278a).

One expert testified that it is typical of many adolescents that, as in L. L.'s case, they will behave poorly and need hospitalization in one environment or with one parent, yet their behavior will be excellent and they will not need treatment in another environment or with the other parent (625a-628a). L. L.'s mother and her two sisters participated with her in therapy sessions "prior to admission because of family quarrels" (166a).[9] Diagnosed "adolescent adjustment reaction," L. L. was discharged to live with her father in Florida" (168a).

M. W. was transferred to Haverford State Hospital after an overnight stay at another facility for ingestion of valium and possible glue sniffing. "Past psychiatric history included the patient having been placed on probation after a drug abuse charge and a court

[9]"On the day of admission the patient felt as she stated 'closed in' by the mother and she threatened the mother with a kitchen knife. The mother contacted Dr. Aernowitz who recommended hospitalization at Haverford State Hospital" (166a).

evaluation . . . . M ____ has a 1½ year history of underachieving, truancy and drug abuse." (169a). Treated with drugs and psychotherapy, M. W. was at one point placed on leave and "brought back by the police after being questioned due to false accusation of stealing" (171a). During the months of his commitment, M. W. complained that he was being confined involuntarily (170a).

One plaintiff, 15 year old V. M., had run away from home (after a psychiatrist advised her family to let her live away from home) when she was brought to the mental institution by the police "after being picked up in the park in an incoherent, assaultive state along with several young men" (174a). With a background including runaways and drug use, V. M., the hospital stated, "vented much hostility towards her family, particularly her father, 'My family is screwed up. What can I do? I tried running away and it just got me in jail' " (175a).

The hospital found "no evidence of a thought disorder" in V. M. and described her "as a frightened girl, who was attempting to strike out at her surroundings in self defense." (175a). V. M.'s family wanted her outside of the home and the hospital agreed (176a) noting that "it seemed desirable to remove the patient from the family setting because the family had been so rejecting of her and scapegoating her" (177a). If the family could not afford a residential institution, the hospital "recommended that the family take the patient to court to be declared incorrigible" (177a). The family succeeded in their desires; V. M. was



transferred to the Devereaux School, a mental health facility.[10]

Under the protection of a court order forbidding retaliation against them, two juveniles, D. D. and A. M., provided the District Court an uncontradicted description of their experiences (34a-37a).

Prior to his commitment under the challenged statutes, there was conflict at home between D. D. and his parents who, due to their own poor physical and emotional reserve, were thought by the hospital to be "likely unable to cope with the *future* demands" D. D. would make on them. (778a). D. D. was reported to have been truant from school and to have been an uncooperative out-patient.

D. D. was on probation from the juvenile court for truancy. He broke probation but, on recommendation of someone at the county courthouse, D. D.'s parents brought him to the hospital:

> When I got to the hospital, the doctor, Dr. Kratsa, wanted me to go to reform school. My parents kept saying no. They made it sound like if I didn't come here I'd be going to reform school. So I said yes. That's how they tricked me.

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[10]The Devereaux School's protestations to the contrary notwithstanding, see Brief of Devereaux School *amicus curiae*, it clearly does not function as a traditional educational facility. Licensed to provide mental health and mental retardation care, it serves only disabled persons and is subject to the state laws challenged here. See *In Re Sippy*, 97 A.2d 455 (D.C. Mun. App. 1953) (holding that child has right to independent counsel prior to commitment to Devereaux School, "a psychiatric school"). In any case, because Pennsylvania commitment laws apply to all facilities, public and private, and because of the class defendant representing all facility directors, see note 1 *supra*, the issue suggested in the amicus brief is not before the Court.

At the institution, on one occasion, D. D. was restricted because he "didn't do clean-up." For not accepting the restriction, he was sent for five days "up the hill" to a locked building where he was subject to homosexual advances. D. D. also got into trouble at the hospital for possession of phenobarbitol tablets which he—and other juveniles—obtained in the hospital.

A. M. was committed to Haverford State Hospital upon transfer from the University of Pennsylvania Hospital. Age 15, he was depressed and preoccupied with suicide. A. M.'s uncontradicted description of his hospital stay is graphic:

> When I first got here they pushed me into a room and told me to take off my clothes and put on pajamas. Then they took me up to the fifth floor. I wasn't expecting to be locked up. It really drives you crazy. They didn't explain anything to me—they put you up there and that's it. My mother says if she knew that she wouldn't have put me in here. I was up there 3 or 4 days before I was sent to Building 9.
>
> They threaten you here—that's the really bad part. You do what we say or you go up the hill or something—restrictions. Like me and D____ D____ – we'll probably get sent up the hill again cause we didn't go to our half hour of art therapy. D____ got sent up for five days because he wouldn't take his restrictions. They don't care—they don't care about anything. The evening and late night staff stinks. The only staff that really cares is the day staff.
>
> I got transferred to Building 4 one night. I cut myself on purpose. My hands were bleeding and they said I was going for a tetanus shot. They didn't explain what they were doing or tell you they were taking you up. They should at least have told my parents. I would still be there but my doctor, Dr. Kratsa, got me back the next day. If you get sent up on a Friday, and your doctor is only here Tuesday, Wednesday, and Thursday, you'll be there till next Tuesday at least. Do you think you can do anything about the restrictions and us getting sent up the hill? (34a-35a).



*The Class*

The record before the District Court includes information regarding the mental institutionalization of all the thousands of juveniles in Pennsylvania facilities as of May 31, 1973 (310a-316a).[11]

The facts in the following eight numbered paragraphs are stipulated by the defendants:[12]

1. Children have been institutionalized in Pennsylvania mental health facilities for the following reasons as noted by the institution: "Runaway, incorrigible," "Violent episodes," "Hostile, attacked children, attempted to set home on fire," "Robbed gas station," "Stole

[11]This information was provided in response to plaintiffs' interrogatories which were transmitted to all facilities by means of a questionnaire which called for reports of the "reason" or "precipitating behavior" for commitment (27a, 773a). The extensive data are collated and summarized at 210a et seq.

[12]The stipulation and admission of these facts (522a-523a) was preceded by the defendants' objection that additional data from the juveniles' medical records should be before the court (288a). To satisfy this objection, the court and parties agreed that the records of ten randomly selected juveniles could be introduced into evidence (317a - 363a). In the listing in the text, only representative cases are noted with the name of the facility and patient number eliminated. In each case, the words used are, verbatim, the words with which the institutions themselves justified the commitment.

truck, car," "Member of gang which participated in robbery," "Delinquent behavior," "Arson," "Runaway," "Runaway, truancy, delinquent behavior."

2. Mental health facilities sometimes cooperate with parents and relatives "farming out their kindred into mental institutions for motives not always worthy."[13]

3. Children have wound up at institutions for the following reasons, in addition to their being mentally retarded:

> "Interim placement while family was on vacation."[14]
>
> A mother placed her child at Western because "father out of household in the military."
>
> "Hyperactivity interfered with the routine of household and disturbed family members."
>
> Western accepted another child from a mother because of "desertion of father."
>
> In another case, a mother and a father who themselves had emotional difficulties institutionalized their child because they held the "problems of the child . . . responsible for their emotional adjustment."

Also, "Family conflicts," "Family problems, needed separation from the family," "Unmanageable at home, attitude of bold indifference, resents all discipline,

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[13]*Kent v. United States*, 401 F.2d 408, 416, n. 4 (D.C. Cir. 1968) (Burger, J., dissenting).

[14]More than ten months after this "vacation," this individual was reported still at the institution; he was committed on July 20, 1972 for a one to two week expected stay. The facility reported the individual still committed as of May 31, 1973 (355a - 362a, 773a). The defendants incorrectly state that this commitment was part of a state-encouraged respite care program. Brief for Appellants at 48.



compulsive eating," "Runaway, conflict with parents," "Neglect, Social Deprivation," "Neglect, unstable home environment," "Mother has tuberculosis," "Emotional instability of mother," "Hospitalization of mother is apparent reason for admission," "No serious behavior problem; admitted due to parents' inability to provide a satisfactory home environment," "Sometimes hyperactive. Illegitimate," "Illegitimate. Inadequate mother."

4. One facility accepted a young boy because "He has no playmates, planned activities, exercise. Presently he does nothing except sit in school and in front of the T.V. at home."

5. Three juveniles were committed to mental institutions because of physical ailments: ulcerated colitis, a psychosomatic complaint, weight loss.

6. There are five juveniles in one hospital for not going to school.

7. A number of juveniles are committed for drug-related activities. One juvenile for a "fake drug overdose".

In Pennsylvania, 503 juveniles were committed in 1972 under Sections 402 and 403 to twenty-one state institutions for the mentally ill; 130 juveniles entered after a court hearing under Section 406 (315a). That same year, 317 juveniles entered nine state institutions for the retarded under the challenged statutes and 39 were committed upon a Section 406 hearing (314a). A substantial number of juveniles are committed not by their parents but rather by welfare or social agencies (310a-313a).

*District Court Decision*

The District Court determined that "the state is required to provide substantial procedures when there is the possibility of erroneously and wrongfully depriving persons of their liberty by committing them to mental institutions." 402 F. Supp. at 1045 (citations omitted); 793a. The stigma and incarceration associated with mental commitments were found to command the observance of due process. Recognizing that "[i]n deciding to institutionalize their children, parents, as well as guardians ad litem or persons standing in loco parentis, may at times be acting against the interest of their children," the District Court held that parents "may not effectively waive personal constitutional rights of their children." 402 F. Supp. at 1047-1048; 798a.

The District Court held that, before they may be institutionalized, plaintiffs and their class are entitled to a probable cause hearing, a post-commitment hearing, written notice, counsel, and if indigent the right to appointment of free counsel, a finding by clear and convincing proof that they are in need of institutionalization, and other rights. 402 F. Supp. at 1053; 810a-811a.

The court noted that it did not "intend nor expect that all of these procedures will be required every time an attempt to institutionalize a child is made." 811a, n. 26; 402 F. Supp. at 1053, n. 26. With the exception of the rights to notice and counsel, these rights may be waived by the child (or, in some specified circumstances, by counsel) upon approval by the unbiased tribunal. *Id.*



After the opinion in this case issued on July 28, 1975, and while the District Court had under consideration the parties' proposed orders, the Pennsylvania Supreme Court initiated contact with the Federal Court with regard to the necessity of state court involvement in future hearings.[15] The state court did not seek any formal involvement[16] and, in fact, expressed appreciation for the opportunity to be "involved in the drafting of a final Order" in this case.[17] The Pennsylvania Supreme Court indicated that it would provide the hearings contemplated by the proposed order, stating "We are aware that perhaps five thousand hearings or more may have to be conducted within the next several months, and are preparing to shoulder that hearing responsibility with full cooperation to your Honorable Court."[18]

The final order of the Three-Judge Court unanimously granting injunctive and declaratory relief was entered on November 17, 1975 and required the defendants to "refrain from accepting or continuing the admission or commitment" of class members without the opportunity for hearing.

The court also declared that in the interim until "an alternate neutral tribunal" was created by the legislature, the facilities of the state court system should be used to provide due process hearings.

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[15]The full correspondence between the courts is reproduced at the Appendix below.

[16]"We realize that we are not a formal party to these proceedings and that our involvement must therefore be peripheral." Appendix, *infra*, letter of October 15, 1975 from Judge Barbieri to Judge Huyett.

[17]*Id.*

[18]*Op. cit., supra* note 16.

*Revised Statute*

On July 8, 1976, Pennsylvania enacted a statute which affects a small portion of the plaintiff class.[19] About 80% of the class are retarded, Brief for Appellants at 48, n. 42, and the revised law does not affect this group at all; they are still subject to the statute and regulations determined unconstitutional by the District Court. For the remaining 20%, the new law lowers the age for parental commitment from 18 to 14, thus continuing a procedure identical in operation to that dealt with by the court below, which was aware of the legislature's proposals.[20]

## SUMMARY OF ARGUMENT

1. It is undisputed in this case that the state must generally provide substantial due process procedures to protect persons from erroneous commitment to mental institutions. *Baxstrom v. Herold*, 383 U.S. 197 (1966); *Specht v. Patterson*, 386 U.S. 605 (1967); *Humphrey v. Cady*, 405 U.S. 504 (1972). See *O'Connor v. Donaldson*, 422 U.S. 563 (1975); *Chaloner v. Sherman*, 242 U.S. 455 (1917); *Minnesota ex rel. Pearson v.*

[19]The relevant portions are reproduced *supra* at 2-5.

[20]The regulations adopted by the state apply to persons 13 and older. See Brief for Appellants at 9-15 and the Dissent, 814a-823a; 402 F.Supp. at 1054-1055. The revised law, like the regulations, also includes a procedure whereby, at some indefinite time after commitment, institutionalization may sometimes be challenged. The legislature's proposal for reducing the age for parental commitment from 18 to 14 is discussed with the District Court at 240a-241a.



*Probate Court of Ramsey County*, 309 U.S. 270 (1940).

2. It is similarly undisputed here that deprivation of a juvenile's liberty by the state for the purpose of treatment and rehabilitation must be accompanied by due process procedures which assure accurate fact-finding. *In re Gault*, 387 U.S. 1 (1967); *McKeiver v. Pennsylvania*, 403 U.S. 528 (1971).

3. The sole disputed question raised on the merits of this case is whether the recognized due process protections apply where the state involuntarily and indeterminately institutionalizes juveniles in mental hospitals upon parental application and without notice, counsel or opportunity for hearing.

4. Confinement in a mental institution deprives persons of their constitutional "right to liberty," *O'Connor v. Donaldson*, 422 U.S. 563 (1975), by placing them in a "total institution" in which every aspect of their lives is regulated by typically impersonal authority. The dangers and potential negative effects of institutional treatment programs are well-known; the process results in what one of the nation's foremost child psychiatrists called, in testimony for the defendants, "an emotional deficiency disease."

5. Institutions are generally underfinanced, understaffed and overcrowded. One study notes that the common practice of moving institutionalized juveniles and staff from one ward to another can be devastating; during a 3½ year period, at least 99 different day staff were on duty with the children being cared for by a total of 246 different adults. The children were each moved at least twice and some as many as eighteen times.

6. Children of differing age and disability are affected in varying ways by the mental health system. Few infants or young children receive specialized services; when disturbances are noted, one professional commentary states, "they are often inaccurately diagnosed." School-age juveniles are more likely to become involved with the mental health system in which they may be placed in one of the residential treatment centers which have sprouted across the country in recent years. The literally dehumanizing effects of these facilities are described in a study written for the federally-supported Project on the Classification of Exceptional Children, created at the prompting of former Secretary of Health, Education and Welfare Elliot L. Richardson:

> A situation of special danger arises, however, from the quality of many residential "treatment centers," which are in reality end-of-the-road custodial placements. Thousands of children have been saved by authentic, intensive residential treatment. Many more thousands have probably been sent to death during life in children's units of large public institutions.

7. Stormy adolescence often results in a loss of control by both parents and children. The conflicts which develop may lead to parental requests for assistance to the state's social sanction systems, juvenile court or mental health. Just as a large proportion of juveniles seen in juvenile court might more appropriately be referred to the mental health system, many young people in mental hospitals would be appropriate candidates for delinquency proceedings. If reform school is the chosen option, the child gets a lawyer and a hearing; the child gets neither if hospitalization is



the choice. "The admission of teenagers to the state hospitals has risen something like 150 percent in the last decade. Instead of being helped, the vast majority are the worse for the experience." These are the conclusions of the Joint Commission on Mental Health of Children, created by Congress in 1965.

8. Despite common stereotypes, it is not simply the degree of intellectual and physical impairment which determines whether a mentally retarded person is institutionalized. Equally crucial are the extent of family disorganization, parental attitudes toward child-rearing and mental retardation, demographic characteristics, availability of community resources and the professional philosophies of those consulted for advice. Parents of retarded persons are driven to seek institutionalization by the state as a means of securing relief from severe physical and emotional burdens and because of a lack of finances and adequate community resources.

9. Across the country, there are thousands of instances in which it is shocking that institutionalization was resorted to or in which it was done not to benefit the child but to benefit the parent or parents. There is little support for a blanket presumption of proper medical or parental action.

10. Many children in institutions are there because of difficulties adjusting to the norms of our society. The psychiatric diagnosis often applied is "adjustment reaction" of infancy, childhood or adolescence; this is attributed to the greater fluidity of all behavior in juveniles and is characterized by such symptoms as overactivity, inattentiveness, shyness, feelings of rejection, overaggressiveness, timidity and delinquency. Difficulty in school, problems with peers, drug use,

hostility and temper tantrums are frequent reasons given for institutionalization of juveniles. The factual allegations supporting such descriptive conclusions are often in dispute and, the way the system of parental commitment operates, there is no available mechanism to resolve such disputes. Many children are committed for "delinquent" non-"insane" behavior, or because parents don't care, or simply because someone didn't know what else to do with them. In a large proportion of cases, it is not even the parent who initiates the "voluntary" commitment process. An overworked social welfare agency, a juvenile court, a relative or others place dozens of juveniles in institutions acting, in the language of the statute, *in loco parentis.*

11. It is clear that some screening process is necessary. Neither parents nor institutions, much less welfare agencies, are presently acting to protect the rights of children in any effective way. It is not possible, in the mental commitment process, for them to act in a conflict-free manner.

12. Most juveniles entering the institutional mental commitment system have never received any psychiatric treatment before, inpatient or outpatient. Once hospitalized, juveniles stay longer than adults; a large proportion of juveniles are not considered by psychiatrists to suffer from any major illness. While adults have benefitted from a national decline in institutionalization, juveniles have not. In 1967, 3% of all persons in state and county mental hospitals were under 18; in 1973, the under-18 group accounted for 4% of the total. The percentage drop in total population was 42% for all ages from 1967 to 1973; for people under 18, the drop was only 12%. The situation is little better for the retarded. Of the nearly 200,000 people in



residential institutions for the retarded, more than 40% are minors. Most of these committed persons could leave the institutions if community services were available.

13. The United States Constitution protects the "primary role of the parents in the upbringing of their children." *Wisconsin v. Yoder,* 406 U.S. 205, 232 (1971). The law presumes that parents generally act in good faith for the benefit of their children and, except in such instances as abuse or neglect, the law will not interfere with the authority of parents to direct the rearing of those for whom they are responsible. The state, as representative of the structure of our society, asserts an interest in maintaining the integrity of the family unit and protecting it against limits on the independence of its functioning. Where parents seek to use their authority in conjunction with the state and its laws to institutionalize a child, the child's right to liberty conflicts with the parent-state right to control the child. Whatever powers parents have, they do not negate the personal constitutional rights – such as the right to liberty – of children. The constitutional guarantees familiar in civil commitment proceedings extend to juveniles.

14. This conclusion is the proper one as this Court, in cases beginning in 1923, has confirmed that the Constitution protects all persons, regardless of age, see *In re Gault,* 387 U.S. 1 (1967), and has impressed a constitutional endorsement upon the proposition that parental authority may be restricted for the benefit of the child. *E.g., Prince v. Massachusetts,* 321 U.S. 158 (1944). The Court has approved limitations on parental powers "if it appears that parental decisions will jeopardize the health or safety of the child, or have a

potential for significant social burdens." *Wisconsin v. Yoder*, 406 U.S. 205, 234 (1971).

15. Most recently, the Court refused to permit parents an "absolute veto" over a child's abortion decision; in such conflict situations, an impartial forum to resolve the dispute might be appropriate. *Planned Parenthood of Central Missouri v. Danforth*, ____ U.S. ____, 44 U.S.L.W. 5197 (July 1, 1976). See also *Bellotti v. Baird*, ____ U.S. ____, 44 U.S.L.W. 5221 (July 1, 1976). Other courts have uniformly agreed that, in the parent-child context, the law must protect the welfare of children, an interest to which the rights of parents must yield. Among the many situations in which parental power has been held properly restricted are juvenile curfews, drinking age laws, sex education, blood transfusions, corporal punishment, visitation, approval of personal injury settlements, organ transplants, sterilization and various monetary matters. The key consideration in all these cases is that society has an interest – independent of parents – in assuring the welfare of children. Parents cannot be permitted any absolute decision-making authority which vitiates their child's constitutional rights or results in a potential for great physical, emotional or social harm to the child.

16. The District Court ordered the defendant state officials to assure that all juveniles presently committed without hearings or counsel under the unconstitutional statutes receive the benefit of "accurate fact-finding," *McKeiver v. Pennsylvania*, 403 U.S. 528, 543 (1971), in a state forum. This was a proper order which did not violate *Preiser v. Rodriguez*, 411 U.S. 475 (1972) or *Wolff v. McDonnell*, 418 U.S. 539 (1973), as the District Court did not order "actual restoration" of liberty to plaintiffs but simply required that proper



state proceedings be afforded persons who never had them. This is identical to the relief upheld by this Court in *Gerstein v. Pugh*, 420 U.S. 103 (1975).

17. There was no requirement in this case that state remedies be exhausted prior to plaintiffs seeking federal relief. Even if there was, there were no state remedies to exhaust as the state habeas corpus statute relied on by appellants, on its face, does not apply to the plaintiff-appellees.

18. Principles of federalism were similarly respected by the District Court. No state proceedings were interfered with; the state executive, judicial and legislative branches are explicitly left free to continue commitment of juveniles, so long as the procedures do not violate the Constitution.

19. The appellants argue that the District Court violated the Eleventh Amendment when it ordered that persons presently incarcerated unconstitutionally be provided state procedures to determine whether they require commitment. The District Court did not award damages or award "equitable restitution" of funds from the state treasury; expenditure of funds to implement the procedural requirements of the decree is incidental to the constitutionally mandated goal of assuring that persons are not erroneously incarcerated. Such impact, held *Edelman v. Jordan*, 405 U.S. 651, 667-668 (1974), is not barred by the Eleventh Amendment. "Equitable restitution" of funds directly to plaintiffs, held in *Eldelman* to resemble monetary damages, is a far cry from requiring compliance with procedural due process.

## ARGUMENT

### I.

### PRIOR TO INVOLUNTARY INDETERMINATE MENTAL INSTITUTIONALIZATION BY THE STATE UPON PARENTAL APPLICATION, JUVENILES ARE ENTITLED TO SUBSTANTIAL PROCEDURAL PROTECTIONS.

#### A. The General Right to Due Process Prior to Mental Institutionalization is Undisputed and Not at Issue in this Case.

The defendants do not dispute that the state must generally provide substantial procedures to protect persons from erroneous commitment to mental institutions:

> There can be no doubt that involuntary commitment to a mental hospital, like involuntary confinement of an individual for any reason, is a deprivation of liberty which the state cannot accomplish without due process of law. Specht v. Patterson, 386 U.S., at 608, 18 L.Ed.2d 527, 87 S. Ct. 1428 (1967). Commitment must be justified on the basis of a legitimate state interest, and the reasons for committing a particular individual must be established in an appropriate proceeding.

*O'Connor v. Donaldson*, 422 U.S. 563, 45 L.Ed.2d at 410 (1975) (Chief Justice Burger, concurring). This Court, in recent years, has consistently upheld claims by inmates of mental institutions to hearing and other procedures protective of their constitutional rights. *Baxstrom v. Herold*, 383 U.S. 197 (1966); *Specht v. Patterson*, 386 U.S. 605 (1967); *Jackson v. Indiana*,



406 U.S. 715 (1972); *Humphrey v. Cady*, 405 U.S. 504 (1972); *McNeil v. Director, Patuxent Institution*, 407 U.S. 245 (1972).[21]

This Court's deep concern that due process be afforded to the mentally disabled is by no means newly conceived. Nearly sixty years ago, in *Chaloner v. Sherman*, 242 U.S. 455 (1917), a challenge was made to state mental incompetency procedures. Speaking for a unanimous Court, Justice Brandeis declared:

> As the plaintiff had notice and opportunity to be heard at each stage of the proceedings, the essential elements of due process of law were fully met, and the court had jurisdiction to enter that orcer.

242 U.S. at 455. See also *Dexter v. Hall*, 82 U.S. 9, 25 (1872) ("... a lunatic needs more protection than a

[21] The lower federal courts have uniformly upheld the application of due process to mental commitments, mandating procedures similar or identical to those required by the District Court here. *E. g., Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972). (Three-Judge Court), vacated and remanded on other grounds, 414 U.S. 473 (1974), on remand, 379 F. Supp. 1376 (E.D. Wis. 1974), vacated and remanded on other grounds, 95 S. Ct. 1943 (1975); *Lynch v. Baxley*, 386 F. Supp. 378 (M.D. Ala. 1974) (Three-Judge Court); *Bell v. Wayne County*, 386 F. Supp. 1085 (E.D. Mich. 1974) (Three- Judge Court); *Dixon v. Attorney General of the Commonwealth of Pennsylvania*, 325 F. Supp. 966 (M.D. Pa. 1971); *Heryford v. Parker*, 396 F.2d 393 (10th Cir. 1968); *In Re Ballay*, 482 F.2d 648 (D.C. Cir. 1973); *In Re Basso*, 299 F.2d 933 (D.C. Cir. 1962); *In Re Barnard*, 455 F.2d 1370 (D.C. Cir. 1971); *Sarzen v. Gaughan*, 489 F.2d 1076 (1st Cir. 1973); *Kendall v. True*, 391 F. Supp. 413 (W.D. Ky. 1975) (Three-Judge Court); *Barry v. Hall*, 98 F.2d 222 (D.C. Cir. 1938); *Doremus v. Farrell*, 407 F. Supp. 509 (D. Neb. 1976); *Suzuki v. Quisenberry*, 411 F. Supp. 1113 (D. Hawaii 1976).

minor." "Both such classes of persons are regarded as under the protection of the law.")

In an attack on Minnesota mental commitment procedures, this Court, *per* Chief Justice Hughes, upheld a statute which provided for a hearing, counsel, confrontation, a record and the right to appeal, explaining:

> We fully recognize the danger of a deprivation of due process in proceedings dealing with persons charged with insanity or, as here, with a psychopathic personality as defined in the statute, and the special importance of maintaining the basic interests of liberty in a class of cases where the law though "fair on its face and impartial in appearance" may be open to serious abuses in administration and courts may be imposed upon if the substantial rights of the persons charged are not adequately safeguarded at every stage of the proceedings. But we have no occasion to consider such abuses here, for none have occurred.

*Minnesota ex rel. Pearson v. Probate Court of Ramsey County*, 309 U.S. 270, 276-277 (1940).[22]

In *Specht v. Patterson*, 386 U.S. 605 (1967), the Court rejected the notion that individual rights can be

[22]See *Logan v. Arafeh*, 356 F. Supp. 1265 (D. Conn. 1972), aff'd mem. sub nom. *Briggs v. Arafeh*, 411 U.S. 911 (1973), where the district court upheld a statute noting that a "judicial decision after receiving evidence from a general physician and a psychiatrist in an adversary hearing is fully adequate to safeguard against involuntary commitment through mistake or abuse." 346 F. Supp. at 1270. The timing of the hearings in *Logan* was justified because of a certification that the committed persons were "dangerous." The statutes in the case at bar require only a finding of "in need of care or observation." 50 P.S. 4402, 4403. The recent Mental Health Procedures Act similarly requires a finding of "in need of treatment." Section 201, *supra* at 2.



bypassed by labelling a procedure "civil" rather than "criminal". Discussing mental commitment proceedings under the Colorado Sex Offender Act, the Court held, "These commitment proceedings whether dominated civil or criminal are subject both to the Equal Protection Clause of the Fourteenth Amendment as we held in *Baxstrom v. Herold*, 383 U.S. 107, 86 S. Ct. 750, 15 L.Ed.2d 620, and to the Due Process Clause." *Specht*, 386 U.S. at 608. See *In re Gault*, 387 U.S. 1 (1967).[23]

The due process required in mental commitments today is not unlike that noted by Blackstone in his *Commentaries*. Before a person could be declared retarded ("an idiot"), a writ *de idiota inquirendo* would be filed and "tried by a jury of twelve men;" a declaration that one was mentally ill (a "lunatic") did not occur until after the lord chancellor, "upon petition or information, grants a commission in nature of the

[23]A case strikingly on point is *Heryford v. Parker*, 396 F.2d 393 (10th Cir. 1968), where a nine year old child was committed to a training school for the feeble-minded and epileptic. While the court recognized that this was a different juvenile situation than in *Gault*, it reasoned:

> But, like *Gault*, and of utmost importance, we have a situation in which the liberty of an individual is at stake, and we think the reasoning in *Gault* emphatically applies. It matters not whether the proceedings be labelled "civil" or "criminal" or whether the subject matter be mental instability or juvenile delinquency. It is the likelihood of involuntary incarceration—whether for punishment as an adult for a crime, rehabilitation as a juvenile for delinquency, or treatment and training for a feeble-minded or mental incompetent—which commands of the constitutional safeguards of due process.

396 F.2d at 396.

writ *de idiota inquirendo*, to inquire into the party's state of mind."[24]

The pervasive concern has been that no person may be caused to suffer a loss of liberty—for whatever reason, including possible psychiatric care—without stringent decision-making requirements designed to minimize the ever-present risk of error.[25]

### B. It Is Undisputed In This Case That Juveniles Are Protected By The Due Process Clause Of the Fourteenth Amendment

Over the past quarter century, this Court has developed the thesis that deprivation of a juvenile's liberty for the purpose of treatment and rehabilitation must be accompanied by due process procedures which assure "accurate factfinding." *McKeiver v. Pennsylvania*, 403 U.S. 528, 543 (1971). The defendants do not dispute the correctness of this development.

*Haley v. Ohio*, 332 U.S. 596 (1948), reversed the murder conviction of a 15 year old boy who was arrested at midnight and signed a confession after five hours of police interrogation. The Court held that "Neither man nor child can be allowed to stand

[24]Blackstone, *Commentaries on the Laws of England* 305 (Wendell, ed., 1852). Just as in Pennsylvania and other states, in Blackstone's day, "The legislature, to prevent all abuses incident to such private custody, hath thought proper to interpose its authority, by statute [citation omitted] for regulating private mad-houses." *Id.*

[25]For discussion of the special difficulties of reliance on psychiatric opinion in this context, see 61-65 *infra*.



condemned by methods which flout constitutional requirements of due process of law," 332 U.S. at 601, and noted:

> What transpired would make us pause for careful inquiry if a mature man were involved. And when, as here, a mere child — an easy victim of the law — is before us, special care in scrutinizing the record must be used.

332 U.S. at 599.

Referring to the unstability and uncertainity of adolescence, the opinion in *Haley* explained:

> He needs counsel and support if he is not to become the victim first of fear, then of panic. He needs someone on whom to lean lest the overpowering presence of the law, as he knows it, crush him.

332 U.S. at 600. See *Gallegos v. Colorado*, 370 U.S. 49, 54 (1962).

The beneficent objectives of juvenile courts provide no justification for arbitrary denial of procedural rights:

> The objectives are to provide measures of guidance and rehabilitation for the child and protection for society, not to fix criminal responsibility, guilt and punishment. The State is *parens patriae* rather than prosecuting attorney and judge. But the admonition to function in a "parental" relationship is not an invitation to procedural arbitrariness.

*Kent v. United States*, 383 U.S. 541, 554-555 (1966) (note omitted). *Kent* held in no uncertain terms that juveniles are entitled to vigorous counsel and to hearings in important matters:

> The right to representation by counsel is not a formality. It is not a grudging gesture to a ritualistic requirement. It is of the essence of justice. Appointment of counsel without affording

> an opportunity for hearing on a "critically important" decision is tantamount to a denial of counsel.

383 U.S. at 561.

In *In re Gault*, 387 U.S. 1 (1967), the Court observed that the purpose of juvenile facilities was for the "child to be 'treated' and 'rehabilitated' and the procedures, from apprehension through institutionalization, were to be 'clinical' rather than punitive." 387 U.S. at 16. The non-legal benefits of a non-paternalistic procedure were cited by the Court as it referred to certain studies relevant to juveniles with difficulties:

> They suggest that the appearance as well as the actuality of fairness, impartiality and orderliness – in short, the essentials of due process – may be a more impressive and more therapeutic attitude so far as the juvenile is concerned.

387 U.S. at 26.

The reasonable doubt standard was extended to juveniles when *In re Winship*, 397 U.S. 358 (1970), was decided. The Court found, as is urged here, that:

> The same considerations that demand extreme caution in fact finding to protect the innocent adult apply as well to the innocent child.

*Id.* at 365.

The Court went on to hold that it matters not that the purpose of the proceeding is "to save the child" where a possibly lengthy deprivation of liberty is involved. 397 U.S. at 365-366. Concurring, Justice Harlan explained that the need for due process protections resulted from the juvenile's "complete loss of liberty through a state-imposed confinement away from his home, family, and friends," and the stigmatization which was involved. 397 U.S. at 374.



In *McKeiver v. Pennsylvania*, 403 U.S. 528 (1971), the Court applied the familiar due process doctrine of "fundamental fairness" and, referring to *Gault* and *Winship*, stated:

> As that standard was applied in those two cases, we have an emphasis on factfinding procedures. The requirements of notice, counsel, confrontation, cross-examination, and standard of proof naturally flowed from this emphasis.

403 U.S. at 543. The result in *McKeiver* is not so much a restriction on juvenile rights as a finding that a jury trial is not "a necessary component of accurate factfinding." *Id.*

### C. The Disputed Issue Before This Court: Does Due Process Apply In Mental Institutionalization of Juveniles by the State Upon Parental Application?

When viewed against the background of the undisputed legal concepts noted above, it would seem evident that a due process hearing is required where the state confines juveniles in mental institutions on application of their parents. This Court has recognized that a "lunacy" action against a juvenile is not barred[26]

[26]In *Francklyn v. Sprague*, 121 U.S. 215 (1887), where a "lunacy proceeding" was brought in court against a juvenile, this Court recognized that such actions were proper:

> In Shelford on Lunacy it is said: "It seems, that a commission of lunacy may issue against an infant; but as the court of chancery has power over infant wards of court and their estates, such a proceeding seems unnecessary during the minority of the ward, except under particular circumstances when the more ample powers given in lunacy may be required for managing their estates." In Stock on Non Compos Mentis, it is also said, that, "infancy is not a ground for withholding a [commission of lunacy], except in so far as it renders such a proceeding unnecessary, by subjecting the infant to another protective power of the Chancellor.

121 U.S. at 229 (brackets in original).

and other courts[27] and commentators[28] have agreed that such proceedings are necessary to protect against

[27]See, *e.g., Saville v. Treadway,* 404 F. Supp. 430 (M.D. Tenn. 1974); *Kidd v. Schmidt,* 399 F. Supp. 301 (E.D. Wis. 1975) held that juvenile mental patients are entitled to preliminary injunction against parental commitment statutes); *J. L. & J. R. v. Parham,* 412 F Supp. 112 (M.D. Ga. 1976), stay granted, ___U.S. ___ 44 U.S.L.W. 3563 (April 5, 1976); *Brown v. Allerton,* Civil Action No. 75-0450-R (filed September 12, 1975) (case dismissed on stipulation that state had amended its statute to provide hearings in juvenile commitments); *In re Long,* 25 N. Ca. App. 702, 214 S.E.2d. 626 (1975).

[28]*E. g.,* Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions,* 62 Cal. L. Rev. 840 (1974); Burt, *Constitutional Rights Of, In, and For Children,* 39 Law and Contemporary Problems 118, 138 (1975):

> These constitutional norms call into question any state program that relies on large-scale, geographically remote, full-time residential institutions for children, even when parents agree to such institutionalization. Constitutional challenges have been mounted, with some success, regarding conditions in these institutions–essentially to establish a "right to treatment" in them. But from the perspective proposed here, the constitutional wrong is not so much the state's failure to deliver promised services as the totality of the state's claim over every aspect of the lives of children in these institutions. These institutions–whether for mentally retarded or seriously emotionally-disturbed or homeless children–are totalitarian, in both the descriptive and the pejorative senses of that word. They are quintessentially the institutions described by Plato and condemned by the Supreme Court in *Meyer:* "the offspring of the inferior, or of the better when they chance to be deformed, will be put away in some mysterious, unknown place, as they should be."

See Tribe, *Childhood, Suspect Classification, and Conclusive Presumptions,* 39 Law and Contemporary Problems 8, 11 (1975):

> This much, at least, the three puzzles have in common: all seem easiest to solve when the issue clearly involves the

*(continued)*



errors and abuse. What makes this case "difficult and unique"[29] is the involvement and acquiescence of parents in the state-imposed confinement of juveniles.

The sole disputed and important question raised here is whether the recognized Due Process protections apply equally when the State (and parents) seek institutionalization as when the state seeks institutionalization without supportive parental involvement. This is the question raised by the appellants: whether due process applies at all, *not* the extent of due process.

### D. Institutionalization Results in Severe Deprivation of Liberty, Other Dangers, Social Stigma, Self-Stigmatization and Discrimination.

Institutional commitment to a mental institution deprives persons of their "right to liberty," *O'Connor v. Donaldson,* 422 U.S. 563 (1975), by placing them in a "total institution" in which every aspect of their lives is regulated by impersonal authority.[30]

*(footnote continued from preceding page)*

> exercise of a right we have come to regard as constitutionally "fundamental," such as the right to bodily liberty or the right to be heard in one's own defense. Childhood need not be destroyed, dissolved, or ignored in order to recognize that when such a right is at stake, the general fact of youth *alone* cannot automatically justify the right's abridgement. (emphasis in original)

[29]District Court Opinion, 796a; 402 F. Supp. at 1047.

[30]Goffman, *Asylums* (1961). As early as 1938, a federal appellate court recognized the similarities between the situation of a patient and that of a prison inmate. *Barry v. Hall,* 98 F.2d 222 (D.C. Cir. 1938). A detailed comparison of the conditions in a psychiatric treatment center and a state prison–demonstrating the restrictiveness of the mental institution–is provided in "Brief

*(continued)*

The dangers and potential negative effects of institutional treatment programs are well-known;[31] the process results in what one of the defendants' own witnesses calls "an emotional deficiency disease" (715a). Children classified both "retarded" and "mentally ill" are subjected – in differing ways – to these dangers.

### 1. Children in the Mental Health System.

While adults have benefitted from a national decline in institutionalization, juveniles have not. In 1967, 3%

*(footnote continued from preceding page)*
of Donald McEwan, Pro Se" in Katz, Goldstein & Dershowitz, *Psychoanalysis, Psychiatry and the Law* 700-702 (1967). See *In re Gault*, 387 U.S. 1, 27 (1967). For further discussion of the nature of mental treatment in the United States, both today and in the past, see *Developments in the Law–Civil Commitment of the Mentally Ill*, 87 Harv. L. Rev. 1190, 1316-1376 (1974); Deutsch, *The Mentally Ill in America* (2d ed. 1949); Grob, *Mental Institutions in America: Social Policy to 1875* (1973); Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (1971); Kittrie, *The Right to Be Different: Deviance and Enforced Therapy* (1971). See also Ellis, *Volunteering Children, supra* note 28, 62 Cal. L. Rev. at 841-844.

[31]Barton, *Institutional Neurosis*, (2d Ed. 1966); Belknap, *Human Problems of State Mental Hospitals* (1956); Gralnick, et al., "Mental Patients in Transition" in Greenblatt (Ed.), *Mental Patients in Transition*, (1961); Schwartz, "Rehabilitation of Mental Hospital Patients," *Public Health Monograph*, No. 17 (1953); Stanton and Schwartz, *The Mental Hospital* (1954); Wing and Brown, *Institutionalization and Schizophrenia*, (1970); Vail, *Dehumanization and the Institutional Career*, (1966). The trial testimony herein describes some of the harmful effects of institutionalization. See testimony of Dr. Ingall at 596a; Dr. Feiner at 474a - 475a.



of the 426, 309 persons in state and county mental hospitals were under 18. In 1973, the under 18 group accounted for 4% of the 248,518 total. The percentage drop in total patient population was 42% for all ages from 1967 to 1973; for people under 18, the drop was only 12%. Dept. of Health Education and Welfare, NIMH, *Statistical Note 113, State Trends in Resident Patients – State and County Mental Hospital Inpatient Services 1967-1973*, Tables 2, 2a and 4.

Most juveniles entering the institutional mental health system have never received any psychiatric treatment before, stay longer than adults,[32] and a large proportion do not suffer from any major "illness."[33] While about a third of juvenile commitments are pursuant to an involuntary civil commitment, 14% appear to be admitted under the procedures challenged here;[34] more

[32]Most juveniles admitted to mental hospitals (53% in 1969) never before received psychiatric treatment; the figure for all age admissions is only 38.7%. Dept. of Health, Education and Welfare, NIMH, Statistical Note 90, *Utilization of Psychiatric Facilities by Persons Under 18 Years of Age, United States 1971*, Table 9. Once in a public or private mental hospital, juveniles stay longer than adults. *Id.* at Table 8.

[33]In 1972, the leading primary diagnosis of juveniles admitted to state and county mental hospitals was "transient situational disorders and behavior disorders of childhood and adolescence." 38% of the 24,677 admissions received this diagnosis. Dept. of Health, Education and Welfare, NIMH, *Statistical Note 111; Age, Sex, and Color Variations in the Diagnostic Distribution of Admissions to Inpatient Services of State and County Mental Hospitals, United States 1972*, Tables 1a and 1b.

[34]Nationally, 14% of mental hospitals admissions of persons under 18 are applied for by another person on the minor's behalf; 33.4% of the juveniles are admitted by means of an involuntary civil commitment. Dept. of Health, Education and Welfare, NIMH, *Statistical Note 105: Legal Status of Inpatient Admissions to State and County Mental Hospitals, United States 1972*, Table 1b.

non-white juveniles than whites are confined without the benefit of a civil commitment.[35]

Few infants or young children are seen in the mental health system; few specialized services exist for this age range.[36] A major problem in the mental health diagnosis of very young children is that "When disturbances are noted, they are often inaccurately diagnosed."[37]

School-age juveniles are more likely to become involved with the mental health system in which they may be placed in one of the residential treatment centers which have sprouted across the country in recent years.[38] The literally devastating effects of these facilities are described in a study written for the Project on the Classification of Exceptional Children, created at the prompting of then Secretary of Health, Education and Welfare Elliot Richardson:

[35]While 38.2% of white juveniles are admitted under involuntary civil commitments, only 19% of non-white juveniles are. White juveniles signed in by another acting in their behalf are 11.7% of admissions while the percentage for non-whites is 20.8%. *Statistical Note 105, supra* note 34, at Table 1b.

[36]Cohen, et al., *Mental Health Services,* in Hobbs (ed.), *Issues in the Classification of Children,* Vol. I, 88, 91 - 98 ( 1975).

[37]*Id.* at 97.

[38]Residential treatment centers (RTC's) provide inpatient (residential) psychiatric services for persons under 18 years diagnosed as emotionally disturbed. Some retarded children may also be served. "As of January 1974, there were 340 RTC's in the United States which maintained a total of more than 19,000 beds . . . ." Dept. of Health, Education and Welfare, NIMH, Statistical Note 130, *Residential Treatment Centers for Emotionally Disturbed Children 1973 - 74* at 2. "The nearly 30,000 children under care in RTC's during 1973 received over 6.3 million days of care." *Id.* at 3.



> A situation of special danger arises, however, from the quality of many residential "treatment centers," which are in reality end-of-the-road custodial placements. Thousands of children have been saved by authentic, intensive residential treatment. Many more thousands have probably been sent to death during life in children's units of large public institutions. For example, in custodial mental hospitals, children with severe developmental disabilities such as childhood autism often have a rapid downhill course marked by increasing isolation, disorganization, and deterioration. Separated from parents and familiar surroundings, these children lose their liveliness and apparent intelligence and succumb to the regimentation and trauma and lack of care and education. As another example, children with borderline personalities and borderline intelligence are often placed in residential centers because of their aggressive or antisocial behavior at home. With punitive treatment, peer socialization into deviance, lack of education, and the absence of incentives toward normal development in many residential institutions, such children often become incapable of ever fully resuming a healthy social role.[39]

Stormy adolescence often results in a loss of control by both parents and children.[40] The conflicts which develop[41] may result in parental requests for assistance to the state's social sanction systems, juvenile court or

[39]*Op. cit., supra,* note 36 at 106.

[40]See Meeks, *The Fragile Alliance* (1971).

[41]The defendants' own witnesses spoke most directly of these conflicts: Testimony of Dr. Tashjian at 651a-652a, 656a-657a, 668a-669a; Dr. Masterson at 727a-728a ("every parent of every patient we see can be called unstable"), 732a-734a; Dr. Miller at 785a ("conflict of interests").

mental health. Just as a large percentage of juveniles seen in juvenile court might more appropriately be referred to the mental health system,[42] many young people in mental hospitals would be appropriate candidates for delinquency proceedings.[43]

The Joint Commission on Mental Health of Children described the failure of hospitalization for adolescents:

> The admission of teenagers to the state hospitals has risen something like 150 percent in the last decade . . . . Instead of being helped, the vast majority are the worse for the experience. The usual picture is one of untrained people working within the framework of long-abandoned theory (where there is any consistent theory), attempting to deal with a wide variety of seriously sick

[42]Lewis, Balla, *et al., Psychotic Symptomatology in a Juvenile Court Clinic Population,* 12 Journal of the American Academy of Child Psychiatry 660 (1973).

[43]The record herein provides numerous examples. See pages 8-16 *supra* for descriptions of the delinquent or criminal bases for juvenile mental commitments as well as the familiar "status offenses" such as truancy and incorrigibility. The mental commitments described took place for both the retarded and for the mentally ill under the challenged statutes. One study of adolescents admitted to inpatient psychiatric services over three years demonstrated that–for the two groups into which the admissions could be divided, nondelinquent and delinquent–the first group's admission to the hospital was judged appropriate. The delinquent group was judged inappropriately hospitalized and not "requiring or benefiting from psychiatric intervention, at least in an inpatient hospital setting." Weiss & Pizer, *Hospitalizing the Young: Is it for their Own Good?* 54 Mental Hygiene 498 (1970), citing the study, Miller & Kenney, *Adolescent Delinquency and the Myth of Hospital Treatment,* 12 Crime and Delinquency 38 (1966).



> youngsters and producing results . . . measured by a recidivism rate that is often 30 to 50 percent, and occasionally higher.
>
> What we have, in effect, is a state of quiet emergency, unheralded and unsung, silently building up its rate of failure and disability and seemingly allowed to go its way with an absolute minimum of attention from the public, and legislators, or the clinical professionals.[44]

### 2. The Mentally Retarded Child

Most mentally retarded persons are not confined to institutions for the retarded; about 75 percent are not in institutions at all.[45] It is estimated that more than 200,000 persons, 10 percent of all the retarded, are in institutions for the retarded.[46] Of these, 42 percent are

[44]Joint Commission on Mental Health of Children, *Crisis in Child Mental Health - Challenge for the 1970's* 6 (1970), as quoted in Hobbs, *The Futures of Children* 131 (1975). The Joint Commission on Mental Health of Children was established by the U. S. Department of Health, Education and Welfare pursuant to Social Security Amendments, July 30, 1965, Pub. L. No. 89-97, §231(a)-(d), 79 Stat., 360. It was composed of "representatives of leading national, medical, welfare, educational, and other professional associations, organizations, and agencies active in the field of mental health of children." *Id.* at §213(c).

[45]Edgerton, *et. al., Mental Retardation System,* in Hobbs, ed., *Issues in the Classification of Children,* Vol. II, 63-64 (1975).

[46]U.S. Department of Health, Education and Welfare, *Mental Retardation Sourcebook* (1972). In 1974, it was estimated that the total number of residents of public residential facilities was approximately 176,000. National Association of Superintendents of Public Residential Facilities for the Mentally Retarded, *Current Trends and Status of Public Residential Services for the Mentally Retarded: 1974* 13 (1975) (hereafter cited "Current Trends"). This source provides estimates based on a national survey of facilities.

aged between 3 and 21 years and 3% are under 2.[47]

While degree of intellectual and physical impairment is a factor in determining institutionalization of retarded individuals, it clearly does not stand alone nor is it necessarily the most important. Other factors are the degree of family disorganization, demographic characteristics, parental attitudes toward childrearing and mental retardation, availability of community resources, and the professional philosophies of those consulted for advice.[48] "Professional philosophies influence decisions because patient oriented clinicians are more likely to give first priority to factors they consider advantageous to the child, whereas family oriented clinicians are more likely to base their recommendations on those which they assume to be best for the family."[49]

The record in this case vividly illustrates how the retarded often find themselves in institutions through fortuitous and avoidable circumstances. For example, one institution explained a commitment in this way:

> Since maternal grandparents have come to live with the family, this has presented serious problems. The maternal grandmother needs constant care but the maternal grandfather has been unable to help and acts as if he hates everyone.

[47]Current Trends, *supra* note 46, at 7.

[48]*E.g.*, Eyman, *et al.*, *Factors Determining Residential Placement of Mentally Retarded Children*, 76 Amer. J. of Mental Deficiency 693 (1966); Gralicker, *et al.*, *A Study of Factors Influencing Placement of Retarded Children in a State Residential Institution*, 69 Amer. J. of Mental Deficiency 553 (1965).

[49]Eyman, *supra*, note 48, at 697.



> The older sister, _____, has also had problems in adjusting to the situation. Mother was said to be close to a nervous breakdown and could no longer cope with both _____ and the maternal grandmother (351a).

Here, no commitment was even contemplated until two grandparents added to the burden of caring for a retarded child. It is no wonder that the mother was close to a breakdown and also no wonder that the helpless child was institutionalized rather than the grandparents who would have been entitled to a lawyer and a hearing for their protection.

Another case:

> The father described her as hyperactive, but the mother said that she was only active. Though the parents stated that she was well accepted at home, they felt that now that she is entering pubescence, it will be better for her to be admitted at this time. The maternal aunt who had been caring for her was away and since she was the one against placement, the parents felt that this was the time to arrange for placement. The brothers, though they love _____, are uncomfortable in her presence (353a).

Thus, in order to avoid providing their child with birth control, and in order to evade a responsible relative who opposed the child's commitment, the hospital and parents chose to confine their child in an institution.

Parents of retarded persons often resort to seeking institutionalization by the state as a means of securing relief from severe physical and emotional strains and

because of a lack of finances and adequate community resources:[50]

> However, if these parents are "given honest information about residential and community alternatives and time to reflect," most of them "come to realize that the placement in most institutions means placing a lid on the child's potential by consigning him to custodial care – sometimes humane but often inhumane by anyone's standards. Most good residential schools (offering education and training as well as care) are extremely expensive. Most state institutions are still little more than warehouses which 'store' people."[51]

The particular dangers of institutionalization for the retarded include a high rate of mortality (generally higher, especially for the young, than in the community), an adverse effect on intelligence and an abnormally high prevalence of personality disorders.[52]

After the emergence of the first institutions for the retarded in the United States 120 years ago in an

[50]See, *e.g.*, Justice, *et al.*, *Problems Reported by Parents of Mentally Retarded Children - Who Helps?*, 75 Amer. J. of Mental Deficiency 685 (1971). Lack of community services was the reason for 50 percent of readmissions to institutions for the retarded in 1973-1974. *Current Trends, supra,* note 46, at 20. "Community rejection" was found to be the cause for 22 percent of such readmissions. *Id.* If appropriate community services were available, 52 percent of the retarded in institutions could leave according to superintendents' own estimates. The percentages are higher for the borderline (98%), mild (86%) and moderate (81%) levels of retardation. *Current Trends,* supra, at 23.

[51]Hobbs, *The Futures of Children* 142 (1975) (citation omitted).

[52]Studies discussed in Edgerton, *et al., supra,* note 45.



atmosphere of optimism, the facilities failed to fulfill their expectations for cure or rehabilitation. By 1880, the earlier prevention model was succeeded by a "pity model" which supported the provision of custodial care. By the turn of the century and with the development of the eugenics movement,[53] a societal image of the retarded as a danger and a menace to society become fixed.[54] As one commentator notes:

> . . . many of our institutions, to this very day, operate in the spirit of 1925 when inexpensive segregation of the scarcely human retardate was seen as the only feasible alternative to combat a social menace. I am not proposing that this view is still held; I am proposing that most institutions function as *if this* view were still held.[55]

This brief exposition demonstrates the invalidity of the defendants' view that the institutionalized retarded should somehow be treated differently from the mentally ill.[56]

[53]See *Buck v. Bell,* 274 U.S. 200 (1927), upholding a statute growing out of this movement.

[54]For an analysis of this historical development, see Baumeister, *The American Residential Institution: Its History and Character* in Baumeister and Butterfield, eds., *Residential Facilities for the Mentally Retarded* (1970); Kugel & Wolfensberger, eds., *Changing Patterns in Residential Services for the Mentally Retarded* (1969).

[55]Wolfensberger, *The Origin and Nature of Our Institutional Models,* in Kugel and Wolfensberger, *supra,* note 54, at 129 (emphasis in original).

[56]Brief for Appellants at 48. The defendants state that in Pennsylvania, "approximately eighty percent of institutionalized juveniles are mentally retarded." *Id.* Note that the new statute does not apply at all to this portion of the plaintiff class. See Section 502, at 5 *supra.*

### 3. Institutional Life

Institutions are generally underfinanced, understaffed, and overcrowded.[57] One study notes that the practice of moving institutionalized juveniles and staff from one unit to another can be devastating; during a 3½ year period, at least 99 different day staff were on duty with the children being cared for by a total of 246 different adults. The children were moved at least twice and some as many as 18 times.[58]

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[57]Hobbs, *supra,* note 51, at 127-128. Provost Nicholas Hobbs notes in his report:

> Most public institutions are grossly and chronically underfinanced (Kugel, 1969). During 1966 and 1967 the per diem costs in United States institutions (except in Alaska) ranged from about $3 to $12 per person (U.S. Department of Health, Education, and Welfare, 1968). In stark contrast, five of the largest United States zoos were spending, in a comparable period, an average of over $7 for their large animals (Kugel, 1969, p. 3). Further, in 1966, general hospital care cost more than $40 per day (Butterfield, 1969, p. 18).
>
> * * *
>
> Overcrowding is commonplace. Many residential facilities have as many as 25 to 50 percent more residents than they were intended to serve. Buildings that are old and poorly designed also create problems. For instance, lavatory and toilet facilities are often poorly maintained and may even be nonfunctioning. Ancient facilities may make it difficult if not impossible to prepare food in a sanitary fashion; and climate control may be so inadequate as to leave buildings either too hot or too cold (Kugel, 1969, pp. 405; Blatt and Kaplan, 1967). Equally inadequate are modern complexes of steel, chrome, and glass, when human caring is absent.

[58]Tizard, *The Role of Social Institutions in the Causation, Prevention and Alleviation of Mental Retardation,* in Haywood, *Social-Cultural Aspects of Mental Retardation* (1970). See *In re Gault,* 387 U.S. 1 (1967).



Nicholas Hobbs, in his report volume of the HEW-sponsored Project on Classification of Exceptional Children, describes how the process of institutionalization can "make children sick:"

> Go to a big state mental hospital in almost any state and ask to visit the children's ward. If you are allowed to visit, you will find people, children and staff alike, caught up in a no-exit game. Patients and staff play their roles, each defined by the other, both prescribed by elaborate regulations and procedures that serve one purpose: to maintain the stability of the institution. Most of these institutions are so large, so unwieldy, so antiquated in design, so poorly staffed, so burdened with the miseries of man that everyone involved must devote most of his energies to maintaining a steady-state situation. The metaphor of illness rules. Change in or deviation from role requirements cannot be tolerated. Apathy goes unnoticed. Precise adherence to role expectation is praised and rewarded, while deviations and serious efforts to change the system are punished. In such a setting, hospitals can indeed make children sick.[59]

As the discussion above indicates,[60] institutionalization is an extreme deprivation of liberty for both the retarded and the mentally ill. It is typically dehumanizing and often dangerous. The consequences of a mistaken commitment of a child are enormous. As the District Court noted, "Neither the state nor plaintiffs have an interest in committing to mental institutions children not in need of institutionalization." 402 F. Supp. at 1050; 803a.

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[59] Hobbs, *supra* note 51, at 130.

[60]See pages 35-47 *supra.*

### 4. Stigma and Discrimination

Severe social stigma, self-stigmatization, job and license discrimination also result from the experience of commitment to a mental institution.[61] This is no less a probelm simply because a parent volunteered the child; parental commitment requires a certification of the juvenile as mentally disabled just as does an administrative or judicial commitment. It is the fact of institutionalization, rather than the manner, which stigmatizes.[62]

The "stigma associated with civil commitment" found by the District Court, 795a; 402 F. Supp. at 1046, affects both the mentally ill[63] and the retarded.[64]

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[61] See Testimony of Dr. Kandler at 574a-575a and Dr. Messinger at 622a. See also *Lessard v. Schmidt, infra* note 63.

[62] "Unfortunately, there is a stigma being attached to being in a hospital, which would be another reason why all care ought to be taken before this type of drastic step be taken. I never heard the fact that a judge or attorney being involved in a proceeding increases that stigma." Testimony of Dr. Kandler at 574a-575a.

[63] *E.g., In re Ballay,* 482 F.2d 648, 668 (D.C. Cir. 1973); *Lessard v. Schmidt,* 349 F. Supp. 1078 (E.D. Wis. 1972), vacated and remanded, 414 U.S. 473 (1974), on remand, 379 F. Supp. 1376 (E.D. Wis. 1974), vacated and remanded 95 S. Ct. 1943 (1975); Braginsky, *et al., Methods of Madness: The Mental Hospital as a Last Resort* (1969). See Testimony of Dr. Ingall at 596a and Dr. Miller at 705a.

[64] *Pennsylvania Association for Retarded Children v. Commonwealth of Pennsylvania,* 343 F. Supp. 279, 293-295 (E.D. Pa. 1972); Edgerton, *The Cloak of Competence: Stigma in the Lives of the Mentally Retarded* (1967); Braginsky & Braginsky, *Hansels and Gretels: Studies of Children in Institutions for the "Mentally Retarded"* (1971). The defendants' assertion in their brief that the mentally retarded are somewhat insulated from stigma is totally without foundation.



The Due Process Clause protects the plaintiffs here because the injury to their standing and reputation does not stand alone but is associated with the deprivation of liberty and other harms which flow from mental commitment. See *Wisconsin v. Constantineau,* 400 U.S. 433 (1971). *Cf. Paul v. Davis,* ____ U.S. ____, 44 U.S.L.W. 4337 (1976).

## E. Parental Powers Are Limited for the Protection of Children.

Under Pennsylvania law, while a parent or guardian on behalf of a juvenile may apply for commitment, only the institutional representative can commit.[65] Counsel for defendants has emphasized that, regardless of the parents' wishes, "the institution still will have the ultimate say in whether or not that child is institutionalized based upon their independent determination – psychiatric determination" (243a).

The defendants argue that this involvement of parents or guardians is sufficient ground to negate the otherwise conceded right of juveniles to due process in mental commitment proceedings. The parental powers authorized by law are so encompassing, it is argued, that the juveniles' rights must yield. The rationale of numerous decisions of this Court indicates otherwise.

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[65] A significant number of juvenile commitments are initiated not by their parents but rather by social welfare agencies, relatives or courts (310a-313a). The recent statute still permits such parental involvement with state commitment. As the defendants' counsel told the District Court, under the revision, "under age 14, he would again be admitted or committed by his parent or the person standing in locus parentis" (241a).

In cases beginning in 1923, this Court has examined the extent to which the Constitution affects the rights of children and the triangular relationship of parent-child-state. The Court has confirmed that the Constitution protects all persons, regardless of age, and has impressed a constitutional endorsement upon the proposition that parental authority may be restricted for the benefit of the child.

*Meyer v. Nebraska*, 262 U.S. 390 (1923), involved what the Court later called "children's rights to receive teaching in languages other than the nation's common tongue." *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944). In *Meyer*, a state law restricting the use of foreign languages in schools was struck down and the Court declared the familiar principle that state interests must often yield to individual rights:

> That the State may do much, go very far, indeed, in order to improve the quality of its citizens, physically, mentally and morally, is clear; but the individual has certain fundamental rights which must be respected.

262 U.S. at 401.

Two years later, when a criminal law requiring parents to send children to public schools was challenged, it was only after noting the contention that the law violated "the right of the child to influence the parents' choice of a school," *Pierce v. Society of Sisters*, 268 U.S. 510, 532 (1925), that the familiar gloss was made that the law

> unreasonably interferes with the liberty of parents and guardians to direct the upbringing and education of children under their control.

*Id.* at 534-535.



However, the possible breadth of this language in *Pierce* was substantially limited in *Prince v. Massachusetts*, 321 U.S. 158 (1944), when the Court upheld restrictions on the rights of guardians and supported certain regulation of family interests:

> But the family itself is not beyond regulation in the public interest, as against a claim of religious liberty. [citations omitted] And neither rights of religion nor rights of parenthood are beyond limitation. Acting to guard the general interest in youth's well-being, the state as *parens patriae* may restrict the parent's control by requiring school attendance, regulating or prohibiting the child's labor and in many other ways.

*Id.* at 166 (notes omitted). Thus, in upholding a child labor law against the Jehovah's Witness guardian of a nine year-old girl, the Court in *Prince* expressed the very interest that plaintiffs herein seek recognition of:

> It is the interest of youth itself, and of the whole community, that children be both safeguarded from abuses and given opportunities for growth into free and independent well-developed men and citizens.

321 U.S. at 165.[66]

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[66]The case of *Ginsberg v. New York*, 390 U.S. 629 (1968), upholding the constitutionality of a New York criminal obscenity law prohibiting the sale to minors under 17 of material obscene to minors, is not contrary authority. First, *Ginsberg* dealt with obscenity which is *not* constitutionally protected; the liberty of the juveniles in the case at the bar, on the other hand, *is* subject to constitutional protection. Second, the Court recognized the narrowness of the issue before it when it declared that it was not considering

> the impact of the guarantees of freedom of expression upon the totality of the relationship of the minor and the State, cf. In re Gault, 387 U.S. 1, 13.

*(continued)*

In *Tinker v. Des Moines Independent School District*, 393 U.S. 503, 506-507 (1969), young persons were held protected by the First Amendment in their school protest against the Vietnam War. The Court declared:

> Students in school as well as out of school are "persons" under our Constitution. They are possessed of fundamental rights which the State must respect, just as they themselves must respect their obligations to the State.

393 U.S. at 511.

*Wisconsin v. Yoder*, 406 U.S. 205 (1971), held that Amish parents could not constitutionally be convicted of violating a compulsory school attendance law when children 14 and 15 years old did not attend until age 16 as the law required. Although indirectly supporting parental interests in the upbringing of children, the Court specifically did not reach the question of what would happen if the state and parents were aligned against the child. 406 U.S. at 231-232 (opinion by Chief Justice Burger) and 406 U.S. at 237 (Justice Stewart, with Justice Brennan concurring). Limitations on parental powers continued to receive approval; such regulation is proper

> if it appears that parental decisions will jeopardize the health or safety of the child, or have a potential for significant social burdens.

406 U.S. at 234.

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390 U.S. at 630. Third, the Court held only that the Constitution supports the parental "claim to authority *in their own household*" to direct the rearing of children, 390 U.S. at 639 (emphasis added); this cannot be read as authority for absolute discretion outside the household and, indeed, the Court held that the state must protect children from abuses, 390 U.S. at 640.



The extent of control over juveniles granted by the law to parents and guardians is broad enough to provide appropriate deference to the "importance of the family," *Stanley v. Illinois*, 405 U.S. 645, 651 (1972), in our society, but narrow enough to protect the independent personal interests of the most powerless of the family's members.[67]

In the recent abortion decisions, parental "absolute power" to overrule an abortion decision was found improper where the juvenile and parent "are so fundamentally in conflict and the very existence of the pregnancy already has fractured the family structure." *Planned Parenthood of Central Missouri v. Danforth*, ____ U.S. ____, 44 U.S.L.W. 5197, 5204 (July 1, 1976). The state's interest in safeguarding the family unit and parental authority do not outweigh the rights of the juvenile. *Id.* It is the "absolute limitation on the minor's right," *Id.*, 44 U.S.L.W. at 5208 (Concurring opinion of J. Stewart, with J. Powell), with no provision for "judicial resolution of any disagreement," *Id.*, which causes the greatest risk of harm to the juvenile and involves the least benefit to legitimate state interests. See *Bellotti v. Baird*, ____ U.S. ____, 44 U.S.L.W. 5221 (July 1, 1976).

While the above cases may be seen as supporting a presumption in favor of parental prerogatives,[68] this

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[67]Dr. Joel S. Feiner testified that " . . . the child has some intrinsic vulnerability based upon the fact the child is dependent to begin with, the child is more controllable in certain ways, the child is also often a newcomer to the setting, the last to be present in this little system . . ." (472a).

[68]See generally Burt, *Developing Constitutional Rights Of, In and For Children*, 39 Law and Contemporary Problems 118 (1975). In none of the cited cases except *Bellotti* and *Danforth* was there any indication that the parents' and children's views were in conflict or that the state was acting with the parent in ways that might be detrimental to the child.

presumption is overcome where the state acts with parents to impose serious deprivations upon juveniles. As our law has developed, despite legitimate hesitation,[69] society's interest in the protection of children has necessitated narrowly-drawn limitations on the individual interests of parents.[70]

Other courts have uniformly agreed that, in the parent-child context, the law as *parens patriae* must protect the welfare of children, an interest to which the

[69]"Tenderness of the individual interests of parents, since legal interference in family relations touches individuals in a particularly sensitive spot, has induced hesitation in changing the established rules, even where reasons for change were evident." Pound, *Individual Interests in the Domestic Relations*, 14 Mich. L. Rev. 177, 187 (1916) (note omitted).

[70]In 1916, Roscoe Pound described the historical process referred to:

> Mere statement of the claims which parents may make with respect to or against children makes it evident that certain other interests must be weighed against these individual interests of parents. Under more primitive social conditions the group interests of the family or kindred largely dictated the legal delimitation of parental and filial interests. In modern times the individual interests of the child came to be given greater weight. Today certain social interests are chiefly regarded. These are on the one hand a social interest in the maintenance of the family as a social institution and on the other hand a social interest in the protection of dependent persons, in securing to all individuals a moral and social life and in the rearing and training of sound and well-bred citizens for the future. The parent's claim to custody of the child and to control over its bringing up has come to be greatly limited in order to secure these interests.

*Id.* at 182 (note omitted).



rights of parents must yield.[71] Among the many situations in which parental "rights" and "powers" have been held properly restricted are juvenile curfews,[72] drinking age laws,[73] sex education,[74] blood transfusions,[75] corporal punishment,[76] visitation,[77] approval of personal injury settlements,[78] abortion,[79] organ

[71]The issue arises most often in custody cases. *E.g.*, *Holtsclaw v. Mercer*, 145 F.2d 388 (D.C. Cir. 1944); *Langan v. Langan*, 150 F.2d 979 (D.C. Cir. 1945); *Bartlett v. Bartlett*, 221 F.2d 508 (D.C. Cir. 1954). See *In re Stuart*, 114 F.2d 825 (D.C. Cir. 1940) (right of parents to control upbringing of children not absolute); *Newton v. Burgin*, 363 F. Supp. 782 (W.D. N. Ca. 1973) (Three-Judge Court), *aff'd.*, 414 U.S. 1139 (1974) (parental constitutional right to control children can be limited by statute).

[72]*Bykofsky v. Borough of Middletown*, 401 F. Supp. 1242 (M.D. Pa. 1975).

[73]*Republican College Council of Pennsylvania v. Winner*, 357 F. Supp. 739 (E.D. Pa. 1973) (Three- Judge Court).

[74]*Cornwell v. State Board of Education*, 314 F. Supp. 340 (D.Md. 1969), *aff'd.*, 428 F.2d 471 (8th Cir. 1970), *cert. den.* 400 U.S. 942 (1970).

[75]*People ex rel. Wallace v. Labrenz*, 411 Ill. 618, 104 N.E.2d 769 (1952), *cert. den.*, 344 U.S. 824 (1952); *State v. Perricone*, 37 N.J. 463, 181A.2d 751 (1962), *cert. den.*, 371 U.S. 890 (1962).

[76]*Ware v. Estes*, 328 F. Supp. 657 (N.D. Tex. 1971), *aff'd.*, 458 F.2d 1360 (5th Cir. 1972), *cert. den.*, 409 U.S. 1027 (1972).

[77]*Comm. ex rel. Heston v. Heston*, 98 A.2d 477, 173 Pa. Super. 260 (1953); *Surrey v. Surrey*, 144 A.2d 421 (D.C. Mun. App. 1958).

[78]*Rafferty v. Rainey*, 292 F. Supp. 152 (E.D. Tenn. 1968).

[79]*In re Smith*, 295 A.2d 238, 16 Md. App. 209 (1972) (mother cannot compel daughter to submit to abortion).

transplants,[80] sterilization,[81] and monetary matters.[82] The key consideration in all these cases is that society has an interest – independent of parents – in assuring the welfare of children. Where the state is involved and there is a potential for conflict in the interests of parents and children, the law provides independent representation for the child.[83]

When viewed in terms of its nature and potential for harm, application for mental institutionalization of a child (whether the commitment is erroneous or not) is an event at an extreme end of the continuum of decisions made by a parent or guardian.[84] The pressured

[80] *Hart v. Brown*, 289 A.2d 385, 29 Conn. Sup. 368 (1972).

[81] *Frazier v. Levi*, 440 S.W.2d 393, 394 (Civil App. Tex. 1969).

[82] *Ellis v. Massenburg*, 126 N.C. 129, 35 S.E. 240 (1900) (action to set aside deed); *White v. Osborne*, 251 N.C. 56, 110 S.E.2d 449 (1959); *Babcock v. Fisk*, 327 Mich. 72 (1950) (control of publicly raised funds).

[83] See, *e.g.*, cases cited at notes 71-82 *supra*. One authority has observed that parents, the state and childcare agencies do not have a "conflict-free interest in representing the child." Goldstein, Freud & Solnit, *Beyond the Best Interests of the Child* 66 (1973).

This Court has had frequent experience with cases in which the property rights of minors have been protected by representation independent of the guardian. *Insurance Company v. Bangs*, 103 U.S. 435 (1880); *United States v. Dunn*, 268 U.S. 121 (1925); *Clarke v. Clarke*, 178 U.S. 186, 193-195 (1900). See also *United States v. Equitable Trust Company of New York*, 283 U.S. 738 (1931) (in lower courts, one court-appointed guardian acted to protect mentally incompetent person from actions of wife and another court-appointed guardian).

[84] But see *Respublica v. Keppele*, 2 U.S. 197 (1793) (Pa. Sup. Ct.), for a more extreme situation, holding that a parent could not bind a child as a servant.



context in which such a decision is made and the tremendous implications of such a decision combine to make imperative strict limits on any exercise of "absolute power" by any authority.

The expert witnesses for all parties agreed that families seeking commitment of allegedly handicapped children are characterized by severe stress, disharmony and dislocation.[85] The problems of children are a function of intrafamilial problems and exist in the context of a weakened family structure with conflict overtly expressed.[86] The juvenile behavior which precipitates institutionalization may be provoked by the parents; there are also many cases where the child may be driven to such behavior by the conflicts at home.[87]

[85] See Testimony of Dr. Kandler at 543a, 553a-554a, 570a-571a; Dr. Ingall at 588a-590a (intrafamilial conflict; child as scapegoat), 601a; Dr. Messinger at 616a-619a; Dr. Tashjian at 651a-652a, 656a-657a; Dr. Masterson at 727a-728a, 733a-734a. *E.g.*, Alanen, *The Family in the Pathogenesis of Schizophrenia and Neurotic Disorders*, 24 Acta Psychiatrica et Neurologica Scandinavica, Suppl. 189 (1966); Lidz, *et al.*, *Schizophrenia and the Family* (1966); Lidz, *et al.*, *The Intrafamilial Environment of Schizophrenic Patients. II. Martial Schism and Marital Skew*, 114 Amer. J. of Psychiatry 281 (1957). See generally Fleck, *Some Basic Aspects of Family Pathology*, in Wolman, ed., *Manual of Child Psychopathology* 189 (1972). For similar findings regarding the retarded, see authorities cited at notes 45, 48 and 50 *supra*.

[86] See Testimony of Dr. Ingall at 588a, 610a; Dr. Messinger at 616a-619a; Dr. Masterson at 733a-734a; Dr. Tashjian at 668a-669a; Dr. Feiner at 467a-469a, 471a-472a, 501a-502a. See authorities cited note 85 *supra*; Wohlman, *Family Dynamics and Schizophrenia*, 6 J. of Health and Human Behavior 147 (1965); Wohlman, *Children Without Childhood: A Study in Childhood Schizophrenia* (1970).

[87] See Testimony of Dr. Masterson at 733a; Dr. Feiner at 468a. One court which noted the possibility that a "breakdown in parental control" of a child could result from failings in the

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The record in this case indicates that parents will often seek to institutionalize children for improper reasons. This stems from honest mistakes, ignorance, lack of community resources or sometimes from malice or ill will.[88] In a significant numbers of cases, the parental purpose of bringing a child to treatment "has been to accuse him, to punish him, to separate him from the home. The motivation is not always good."[89]

Experts for both plaintiffs and defendants were in agreement that parents are not particularly good observers of children's behavior and symptoms and, especially with the high feelings that run in conflict situations, parents are not reliable sources of factual information about the child and his or her behavior.[90] Parents who bring their child to psychiatrists seeking care "can't be objective reporters" of the behavioral background of the child.[91] Parents often exaggerate and

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parent rather than in the minor, required inquiry into "intra-family parent-child conflict." *In re Henry G.*, 28 C.A.2d 276, 284-285, 104 C.R. 585 (1972), describes the issue in this way:

> The Fourth Commandment is still an integral part of the beliefs of our society. It is one thing, however, to say that a teen-age minor has struck the parent—it is another thing if that striking is done in self-defense and in response to traumatic situations initiated by the parent.

[88]See Testimony of Dr. Kandler at 543a, 553a-554a; Dr. Miller at 685a ("conflict of interest between adolescents and their parents"). See notes 45, 48 and 50 *supra.*

[89]Testimony of Dr. Ingall at 601a.

[90]See Testimony of Dr. Masterson at 733a; Dr. Kandler at 543a; Dr. Ingall at 592a, 601a; Dr. Sugar at 401a.

[91]Testimony of Dr. Feiner at 478a. See Testimony of Dr. Messinger at 623a-624a.



misinterpret the actions of their children and may often react antagonistically to their children.[92]

The decision of the lower court that parents' interests do not negate the rights of their children in the mental commitment context was manifestly correct.[93] Where parents in this conflict situation apply to

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[92]See Testimony of Dr. Sugar at 404a-408a. For the particular pressures on parents of the retarded, see authorities cited at notes 45, 48 and 50 *supra.* See also notes 85-87 *supra.*

[93]401 F. Supp. at 1048; 798a. The District Court and the defendants approach the issue as one of parental power to "waive" children's rights. While the result is the same, plaintiffs do not believe that the constitutional concept of waiver is relevant in this conflict situation. There is no case in which parents have been found to have waived the constitutional rights of their children or not to have waived them. *Gault* discussed the issue of waiver with the Court noting that problems might arise "depending on the age of the child and the presence and competence of the parents." 387 U.S. at 55. See *Heryford v. Parker,* 396 F.2d 393, 396 (10th Cir. 1968) (issue described but not decided).

In plaintiffs' view, the critical question is whether juveniles can be *deprived* of their rights by the state, acting on parental application. As Judge Urbom held in *Horacek v. Exon,* Civil Action No. 72-L-299 (D. Neb., Memorandum and Order of June 4, 1974), cited by the District Court at 797a:

> Equating the plaintiffs with their parents will not do. Such an elementary example as parental child abuse is enough to illustrate that a child has rights a parent cannot take away. Without detailed explanation, I simply hold that parents cannot deprive their children of constitutional rights—rights of the children vis-a-vis the state.

This approach is consistent with that followed by this Court in the parental consent to abortion cases where the effect of parental powers on children's rights was assessed without the

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the state for confinement of their children in residential mental institutions,[94] the "fundamental fairness" of due

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need to inquire into parental competence to "waive" the rights involved. See *Danforth* and *Bellotti, supra* at 53.

Should the Court undertake to consider the waiver issue, plaintiffs submit that parental application for state commitment without more cannot be considered a valid waiver of a child's rights to counsel and an opportunity to be heard. A waiver of constitutional rights must be made "voluntarily, knowingly and intelligently." *Miranda v. Arizona,* 384 U.S. 436 (1966). There must be an "intentional relinquishment or abandonment' of a fully known right." *In re Gault,* 387 U.S. 1, 42, quoting *Johnson v. Zerbst,* 304 U.S. 458, 464 (1938).

A valid waiver may not be presumed from the silence of the person involved. *Miranda v. Arizona, supra; In Re Gault, supra,* 387 U.S. at 34. In cases involving juveniles, even apparent waivers have been invalidated. *E.g., Haley v. Ohio,* 332 U.S. 596, 601 (1948).

[94]Most parents would no doubt prefer not to institutionalize their children if they had the means to actualize alternatives. Where the desire to institutionalize is formulated, it is by no means certain (as defendants assume) that parents would oppose a due process hearing to protect their child. In the case at bar, the District Court suggested that parents' views be represented by the involvement of an organization of "parents of either retarded or mentally disturbed children . . . [as] an appropriate class action defendant" (234a). The *state defendants* initially *opposed* such parental representation arguing that it is the mental institution that has "the ultimate say in whether or not that child is institutionalized" (243a). In view of the Court's request, the defendants agreed to cooperate with the plaintiffs and dozens of contacts resulted in only one parent group joining the litigation. The Pennsylvania Association for Retarded Citizens filed a brief supporting the plaintiffs (4a).



process requires, at the least, notice, counsel and an opportunity to be heard.[95]

### F. Reliance Upon Psychiatrists Alone to Authorize Commitments is Misplaced.

The state defendants argue that the decision to confine a person in a mental institution is a medical one, accomplished for the benefit of the child, and that therefore a due process hearing is not required; mere approval by psychiatrists should suffice.[96]

[95]*Accord, J.L. & J.R. v. Parham,* 412 F. Supp 112, (M.D. Ga. 1976), stay granted, ___ U.S. ___ , 44 U.S.L.W. 3563 (April 5, 1976); *Kidd v. Schmidt,* 399 F. Supp. 301 (E.D. Wis. 1975) (juvenile mental patients held entitled to preliminary injunction against parental commitment statute); *Saville v. Treadway*, 404 F. Supp. 430 (M.D. Tenn. 1974); *In re Long,* 25 N.Ca.App. 702, 214 S.C.2d 626 (1975). See *In re Sippy,* 97 A.2d 455 (D.C. Mun. App. 1953, in which a mother sought to have her teenage daughter committed to a psychiatric facility, the Devereaux School, an *amicus* herein. The court found that the mother's interests were "antagonistic or at least sharply opposed" to the daughter's and held that it was error to permit the mother's attorney to represent the child. See also *New York State Association for Retarded Children v. Rockefeller,* 357 F. Supp. 752, 762 (E.D.N.Y. 1973); *Melville v. Sabbatino,* 30 Conn. Supp. 320 (Super. Ct. 1973).

[96]While the defendants at times appear to argue that parental discretion is unfettered in the institutionalization context, they rely on the institution's acceptance of the commitment application as the "fail-safe" to protect the juvenile's rights. Thus, the defendants appear to have fully abandoned their argument to the District Court that due process does not apply at all to this situation. 791a-793a; 402 F. Supp. at 1044-1045.

A mental commitment authorized by state law is without question a variety of deprivation which falls within the "liberty" clause of the Fourteenth Amendment, *O'Connor v. Donaldson*, 422 U.S. 563 (1975), and substantial procedural protections must accompany such a deprivation.[97] The magnitude of the state action, taken together with both the dangers inherent in commitment and the risks of error, demand a rigorous "emphasis on fact-finding procedures." *McKeiver v. Pennsylvania*, 403 U.S. 528, 543 (1971).[98] See *Specht v. Patterson*, 386 U.S. 605 (1967); *Baxstrom v. Herold*, 383 U.S. 107 (1966).

Mere approval by two psychiatrists[99] cannot support a commitment to a mental institution. *Dixon v. Attorney General of the Commonwealth of Pennsylvania*, 325 F. Supp. 266 (M.D. Pa. 1971).

Certainly, the state of the art of psychiatry is not such that the confinement of tens of thousands of persons should be left to the judgement of these practitioners alone. This field is beset with "uncertainty of diagnosis" and "tentativeness of professional judge-

[97]See cases cited *supra* at note 21.

[98]This case does not involve "second-guessing a medical diagnosis" or interference with the provision of standard medical care to juveniles. Brief for Appellants at 42. It is only when medical recommendations result in a deprivation of liberty, non-medical risks and imposition of stigma that, as in the case at bar, the protections of due process are triggered.

[99]This is what is required by the regulations supported by the defendants and rejected by the District Court.



ment." *Greenwood v. United States*, 350 U.S. 366 (1956).[100]

Mental illness is defined by the user of the term and that definition depends upon the norms employed by the definer:

> And, because of the unavoidably ambiguous generalities in which the American Psychiatric

[100]One important study showed that diagnoses of psychiatric residents were highly influenced by the imagined socio-economic status of the patient and by the perceived diagnosis of other psychiatrists *independent* of the clinical picture presented. Lee & Temerlin, *Social Class, Diagnosis and Prognosis for Psychotherapy*, in *Psychotherapy: Theory, Research and Practice* 181 (1970). See Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 Cal. L. Rev. 693 (1974), for a full review of the literature and the legal implications. Among the studies which support the above proposition include: Beck, *Reliability of Psychiatric Diagnoses: A Critique of Systematic Studies*, 119 Amer. J. of Psychiatry 210 (1962); Chesler, *Women and Madness*, (1972) (Chapter 2 "Asylums"); Edelman, *Intra-Therapist Diagnostic Reliability*, 25 J. of Clin. Psychology 394 (1969); Goldbert & Werts, *The Reliability of Clinicians' Judgements: A Multi-Trait–Multi-Method Approach*, 30 J. of Consulting Psychology 199 (1966); Katz, Cole & Lowery, *Studies of the Diagnostic Process: The Influence of Symptom Perception, Past Experience and Ethnic Background in Diagnostic Decisions*, 125 Amer. J. of Psychiatry 937 (1966) (44 experienced psychiatrists viewed a filmed interview with a patient. 17 saw the person as psychotic, 26 saw the patient as nonpsychotic. When British and American psychiatrists were compared, the British saw less pathology); Pasamanik, Divity & Lefton, *Psychiatric Orientation and Its Relation to Diagnosis and Treatment in a Mental Hospital*, 116 Amer. J. of Psychiatry 127 (1959); Rosensweig, *et al.*, *A Study of the Reliability of the Mental Status Examination*, 117 Amer. J. of Psychiatry 1102 (1961).

> Association describes its diagnostic categories, the diagnostician has the ability to shoehorn into the mentally diseased class almost any person he wishes, for whatever reason, to put there.

Livermore, Malmquist and Meehl, *On the Justifications for Civil Commitment*, 117 U. Pa. L. Rev. 75, 80 (1968).[101]

Institutional psychiatrists are faced with conflicts of interest – with their facilities,[102] with their patients and their patients' families[103] – and have great difficulty in

[101]See Roth, Dayler and Lerner, *Into the Abyss: Psychiatric Reliability and Emergency Commitment Statutes*, 13 Santa Clara Law. 400, 403 (1973). More than a hundred years ago, a court noted that commitment of children to reform school was based on differing perceptions of the status of "poor parental care:"

> . . . there is not a child in the land who could not be proved, by two or more witnesses, to be in this sad condition.

*People ex rel. O'Connell v. Turner*, 55 Ill. 280 (1870). The situation is the same today with regard to who can be proved in the "sad condition" of mental disturbance.

[102]See Testimony of Dr. Messinger at 629a-630a (pressures on psychiatrists to confirm colleagues' opinions and meet institutional needs) and Dr. Ingall at 599a (overcrowded clinics may overrecommend institutionalization).

[103]See Scheff, *Being Mentally Ill: A Sociological Theory* 148-149 (1966) (family request cases are generally automatic). Scheff also discusses a case in which a psychiatrist recommended a commitment for a young patient who was *not* thought mentally ill but who was having difficulties with his parents. *Id.* at 147. Where parents seek commitment of their child, the medical authority is forced to wear two hats:

> While the goal of the psychiatrist will be expressed–and perceived–as the best welfare of the child-patient, it is the parent who has come to seek help, whose situation seems

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telling the sane from the insane, tending toward an overdiagnosis of mental illness.[104] Psychiatry, asked to adjudicate interpersonal and societal conflicts, is often called upon to be the agent of the state's police powers in ways that carry it beyond its expertise.[105]

### G. Need For and Functions of a Hearing.

One expert cogently listed the issues to be faced and decided at a mental commitment hearing for juveniles:

> I think first of all, an agreement on what are the facts.
>
> Secondly, some assessment of how severe the pathology or disturbance of the child is.

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> the most desperate, who seems the most reliable source of information about what is wrong, who is the closest to the psychiatrist in age and social outlook, and who is paying the psychiatrist's fee.

Ellis, *Volunteering Children, supra* note 28, 62 Cal. L. Rev. at 868 (note omitted). This view is confirmed by the expert testimony herein for both plaintiffs and defendants. See Testimony of Dr. Feiner at 472a, 478a-479a; Dr. Sugar at 381a; Dr. Masterson at 732a-733a; Dr. Kandler at 542a; Dr. Ingall at 593a-594a; Dr. Messinger at 637a-638a.

[104]See Rosenhan, *On Being Sane in Insane Places*, 13 Santa Clara Law. 379 (1973), discussed in District Court Opinion at 804a, n. 20; 402 F. Supp. at 1050, n. 20. Indicative of this approach is the testimony for the defendants of Dr. Masterson who asserted that psychiatrists should first assume that the person before them is mentally ill (739a). See testimony at 737a-738a.

[105]See Bazelon, *Forward, Symposium: Mental Illness, the Law and Civil Liberties*, 13 Santa Clara Law. 367 (1973); Szasz, *Civil Liberties and the Mentally Ill*, 9 Clev-Mar. L. Rev. 399, 407 (1960).

> Thirdly, how dangerous the situation is, or might become.
>
> Fourthly, what else has been tried or might be tried.
>
> Fifth, what the adolescent himself says about the matter and what he thinks might be best for him and six, what the family thinks would be best for the boy [or girl].[106]

This is what the plaintiffs seek.

A pre-commitment judicial hearing for juveniles is proper and necessary in non-emergency situations.[107] Because of their immaturity and lack of experience, it is even more important that juveniles receive the protection of a hearing than adults.[108] This is especially true for those very young persons whom the state law totally neglects.

Assistance of counsel is essential and can help treatment of juveniles and can in no significant way hinder such treatment.[109] A hearing would not be unduly traumatic for juveniles and would not interfere with treatment or the parent-child relation; to the contrary, a hearing would encourage more appropriate

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[106]Testimony of Dr. Messinger at 640a. The manner in which these hearing functions affirmatively benefit the child is documented in the brief *amicus curiae* of the State of New Jersey, Department of the Public Advocate.

[107]See Testimony of Dr. Kandler at 542a - 545a, 566a, 571a - 572a, 573a - 574a; Dr. Ingall at 596a - 597a, 606a; Dr. Messenger at 622a - 623a, 625a, 630a - 631a; Dr. Feiner at 479a - 480a.

[108]See Testimony of Dr. Kandler at 562a; Dr. Ingall at 589a - 590a; Dr. Messinger at 630a - 631a.

[109]See Testimony of Dr. Kandler at 542a - 543a; Dr. Ingall at 597a; Dr. Messinger at 633a.



resolution of problems, and would have a positive and beneficial affect on the child.[110] See *In re Gault*, 387 U.S. at 26.[111]

Establishment of a due process forum for a decision to institutionalize lifts the heavy responsibility from the parents[112] and reduces the possibility that the therapist will be seen by the juvenile as an adverse party.[113] A hearing does not interfere with therapy and has the further effect of encouraging a juvenile's cooperation with a treatment plan.[114]

The opportunity for hearings would not discourage people from seeking treatment for juveniles, but would result in agencies and psychiatrists performing more effectively and in the avoidance of the necessity for hearings and of institutionalization.[115]

### H. The Requisites for a Due Process Hearing.

As the defendants cast their appeal, the only issue raised on the merits is the proper extent of parental

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[110]See Testimony of Dr. Kandler at 543a - 545a, 565a - 566a, 574a; Dr. Ingall at 591a, 596a - 597a, 611a - 613a.

[111]One expert, Dr. Feiner, testified that "... it has been said that some children would rather be fair than be loved. So, there is a sense that a judicial hearing responds to in children" (483a). See Testimony of Dr. Messinger at 624a.

[112]Testimony of Dr. Feiner at 481a, 495a.

[113]Testimony of Dr. Messinger at 624a - 625a; Dr. Ingall at 612a - 613a.

[114]Testimony of Dr. Kandler at 561a, 574a; Dr. Ingall at 597a; Dr. Messinger at 633a.

[115]See Testimony of Dr. Kandler at 574a; Dr. Messinger at 638a - 640a; Dr. Feiner at 494a - 495a.

authority in the context of state institutionalization.[116] No claim is made—if the District Court correctly determined that parental rights do not negate children's commitment rights—that the District Court erred in its prescription of notice, counsel, hearing and a "clear and convincing" standard of proof. Thus, this appeal does not raise any question regarding the *extent* of due process that applies in mental commitments.

The requirements of due process are flexible and depend upon an evaluation of the effect of government action on the private interest involved. *Cafeteria Workers Union v. McElroy*, 367 U.S. 886, 895 (1961). Notice, counsel, and an opportunity to be heard are fundamental requirements where a deprivation of liberty—for whatever reason—is involved. *E.g., Specht v. Patterson*, 386 U.S. 605 (1967); *Baxstrom v. Herold*, 383 U.S. 107 (1966); *In re Gault*, 387 U.S. 1 (1967).

In this case, the District Court narrowly shaped plaintiffs' relief, requiring only a hearing before "an unbiased tribunal" (rather than a judicial hearing)[117] and other procedures following, in the main, *Gault* and similar cases. The right to a jury trial was rejected[118] as

[116]This was not the defendants' position in the court below, where they maintained that "the requirements of due process do not apply to the institutionalizing of children . . . ." 791a; 402 F. Supp. at 1044-1045.

[117]The court below did not decide whether a judicial hearing is required on either Due Process or Equal Protection grounds; the issue is not before this Court on appeal. Note that the new Mental Health Procedures Act provides juveniles who challenge commitments with judicial hearings. *Supra* at 4.



was the right to a pre-commitment hearing.[119] All the procedures save notice and counsel, declared the District Court, may be waived upon approval by the unbiased tribunal; a full hearing need not take place every time a juvenile is institutionalized.[120]

Because the defendants have not briefed, argued or challenged the rudiments of due process the District Court required, the plaintiffs will merely summarize them to demonstrate that the procedures are well within the range of those suggested by decisions of this Court and the lower federal courts.[121]

### 1. Notice

Without advance notice, the District Court correctly held, the fundamental "right to be heard has little significance."[122] In mental commitment cases, notice is

[118]See *McKeiver v. Pennsylvania*, 403 U.S. 528 (1971).

[119]A major justification for denial of an invariable right to a pre-commitment hearing was the state's "interest in the immediate detention of children who may be dangerous to themselves or others." 800a-801a; 402 F. Supp. at 1049. Thus, the decision does not threaten to foreclose proper expeditious procedures in emergency situations.

[120]"We neither intend nor expect that all of these procedures will be required every time an attempt to institutionalize a child is made." 811a, n. 26; 402 F. Supp. at 1053, n. 26.

[121]See cases cited at note 21 *supra*.

[122]802a; 402 F. Supp. at 1050, citing, *inter alia*, *Grannis v. Ordean*, 234 U.S. 385, 394 (1914); *In re Gault*, 387 U.S. 1 (1967); *Mullane v. Central Hanover Trust Co.*, 339 U.S. 306 (1950).

at least as essential, if not more so, than in proceedings which do not result in deprivation of liberty. *Cf., Goldberg v. Kelly,* 397 U.S. 254 (1970). Where a proceeding will be held which will determine whether a person is indeterminately and involuntarily institutionalized, advance notice is imperative.

The speculative fear of an unspecified trauma flowing from notice cannot justify abandonment of this first step in providing a process which is due under the circumstances. *In re Gault,* 387 U.S. 1 (1967). In its recent comprehensive study, the American Bar Foundation noted:

> The humanitarian desire to eliminate or curtail the use of notice in such cases raises certain questions, however. It may be, for example, that the experience of receiving notice would prove no more traumatic for the patient than the experience of suddenly finding himself detained in a mental institution.[123]

The record in the case at bar supports the conclusion that this element of due process would not traumatize the juveniles involved. See references at notes 107-111 *supra.*

Requiring written notice of the date, time and place of the hearing and a statement of the grounds for the proposed commitment,[124] the District Court acted to "protect children not in need of institutionalization from wrongful commitment and improper deprivation

[123]American Bar Foundation (Brakel & Rock, eds.), *The Mentally Disabled and the Law* 51 (1971).

[124]803a; 402 F. Supp. at 1050.



of their liberty."[125] Notice is one of the two rights (the other is the right to counsel) which were held to be unwaivable. 811a, n. 26; 402 F. Supp. at 1053, n. 26. This makes good sense. "Since effective notice is a prerequisite to the exercise of an individual's other due process rights, mandatory notice should itself be a requirement of due process" in mental health cases. Note, *Developments in the Law—Civil Commitment of the Mentally Ill,* 87 Harv. L. Rev. 1190, 1274-1275 (notes omitted) (1974) (hereafter cited "Developments").[126]

### 2. Counsel

In criminal proceedings, *Argersinger v. Hamlin,* 407 U.S. 25 (1972), and in juvenile proceedings, *In re Gault,* 387 U.S. 1 (1967), the guiding hand of counsel is a right which assures that no person is deprived of liberty without the aid of an expert able to "cope with problems of law, to make skilled inquiry into the facts,

[125]*Id.* Eighty years ago, in a landmark and often-cited case, the Kansas Court of Appeals explained the logic of requiring notice in mental commitment proceedings:

> Notice and opportunity to be heard lie at the foundation of all judicial procedures. They are fundamental principles of justice which cannot be ignored . . . it will not do to say that it is useless to serve notice on an insane person; that it would avail nothing because of his inability to take advantage of it. His sanity is the very thing to be tried.

*In re Wellman,* 3 Kan. App. 100, 103, 45 P. 726, 727 (1896).

[126]Because some juveniles may not understand the notice, the juvenile's attorney must receive it as well. 803a, n. 19; 402 F. Supp. at 1050, n. 19.

to insist upon regularity of the proceedings and to ascertain whether he [or she] has a defense and to prepare and submit it." *Gault*, 387 U.S. at 36.[127]

Without counsel, a juvenile would be helpless; the right to be heard would be of little avail. *Argersinger, supra*, 407 U.S. at 31. Mandatory appointment of counsel in juvenile commitments assures that a child has the full support necessary to avoid pressures of family and institutions and to assist in making the critical decision whether to waive an evidentiary hearing. See *Gallegos v. Colorado*, 370 U.S. 49, 54 (1962); *Haley v. Ohio*, 332 U.S. 596, 599-601 (1948). See also Harris, *Mental Illness, Due Process and Lawyers*, 55 A.B.A.J. 65 (1969) (danger that young persons will be induced to commit selves to mental institution unless their rights are explained to them by lawyers). With parents, doctors and psychiatric workers all urging commitment, and with no independent confidant, it is unlikely that a child can make an "intentional relinquishment or abandonment" of a fully known right. *Johnson v. Zerbst*, 304 U.S. 458, 464 (1938).

### 3. Hearing

Both a probable cause hearing and a full hearing must occur within a reasonable period of time in order to support an indefinite mental commitment. *In re Barnard*, 455 F.2d 1370 (D.C. Cir. 1971); *Lessard v. Schmidt, supra* note 21. In order to determine if "the nature and duration of confinement bear some

[127]Other recent mental health cases support the right to counsel. *E.g., Lessard v. Schmidt; Lynch v. Baxley; Heryford v. Parker*, all *supra* at note 21.



reasonable relation to the purpose for which the individual is committed," *Jackson v. Indiana*, 406 U.S. 715, 738 (1972), a hearing is indispensable. See *McNeil v. Director, Patuxent Institution*, 407 U.S. 245 (1972). Because of the inadequate record in this regard, and because of the need to permit states the flexibility to experiment with various time frames, there is no need for the Court in this case to specify the times by which hearings must be held.

### 4. Presence of Person

While the right to be present is not absolute, *Illinois v. Allen*, 397 U.S. 337 (1969), there can be no doubt that persons subject to civil commitment have a right to be present, *Specht v. Patterson*, 386 U.S. 605 (1966), and that the right has value to others beside the subject of the proceedings. The individual's appearance provides the factfinder with an opportunity to observe his or her demeanor and to compare observations with those of the psychiatrists, parents and other witnesses. See Note, *Developments, supra* at 71, 87 Harv. L. Rev. at 1282-1283. This "day in court" permits the juvenile to challenge the accuracy of reports of alleged conduct which prompted the initiation of the proceedings.

### 5. Rights at the Commitment Hearing

The District Court held that "because of the tremendous personal as well as societal loss error might cause," juveniles facing involuntary indeterminate mental institutionalization are entitled to "the rights to

confront and to cross-examine witnesses against him, to offer evidence in his own behalf and to offer testimony of witnesses. . . ." 810a; 402 F. Supp. at 1053. These traditional factfinding tools are essential in the commitment process so that conflicts may be resolved and the true state of affairs ascertained. *Specht v. Patterson, supra,* 386 U.S. at 610; *Lynch v. Baxley,* 386 F. Supp. 378, 394 (M.D. Ala. 1974), citing, *Washington v. Texas,* 388 U.S. 14, 19 (1967).

**6. Standard of Proof**

The dangers of erroneous commitment must be weighed against the dangers of not committing those who may be said to require institutionalization; this is the analysis required to determine the appropriate standard of proof. While in juvenile proceedings, this Court has required a reasonable doubt standard, *In re Winship,* 397 U.S. 358 (1969), lower courts are divided on the standard to be utilized in the similar mental health context. See *In re Ballay,* 482 F.2d 648 (D.C. Cir. 1973) (reasonable doubt); *Lessard v. Schmidt, supra* at note 21 (reasonable doubt); *Suzuki v. Quisenberry,* 411 F. Supp. 1113 (D. Hawaii 1976) (reasonable doubt); *Lynch v. Baxley,* 386 F. Supp. 378 (M.D. Ala. 1974) (clear, unequivocal and convincing); *Dixon v. Attorney General of the Commonwealth of Pennsylvania,* 325 F. Supp. 966 (M.D. Pa. 1971) (clear, unequivocal, convincing). Because both the delinquency and the mental health processes involve a "complete loss of liberty through a state-imposed confinement" and severe social stigma, *In re Winship, supra,* 397 U.S. at 374 (Harlan, J.), the plaintiffs submit that the District Court erred in not requiring the higher standard of proof.



The District Court here adopted the clear and convincing standard, choosing not to follow *Winship* because the undeveloped state of psychiatry "creates too great a risk of erroneously releasing children in need of institutionalization." 809a; 402 F. Supp. at 1053.

Although clearly sustainable, the District Court's decision on the standard of proof need not and ought not be addressed by this Court in the absence of any argument on the issue by the defendants and in light of the conflict among the courts, a conflict not present on the other issues discussed above.

**I.**

**I. Neither the State's Regulations nor the Revised Statute Affect the Unconstitutionality of Commitment without Hearing and Counsel**

After the filing of this lawsuit, the defendants adopted regulations[128] which would apply to juveniles in commitments upon parental application. A referral to the institution is required and, only for persons at least thirteen, notice is given that, if objection is made, legal counsel can be called. After at least two days of institutionalization, a court proceeding may be instituted against the objecting juvenile. There is no requirement that the hearing be held at any particular time after commitment–it may take one week, two weeks, a month or more, for all the regulations neglect

[128]Reproduced at Brief for Appellants 9-15.

to say, until due process is afforded that small portion of the class between 13 and 18. There is no provision at all for persons under 13 who are at least equally in need of protection.

The referral body's psychiatric or psychological evaluation, confirmed by the institution, is not a proper legal basis for commitment. It is unconstitutional for persons to be placed in mental facilities solely on the basis of medical certifications. *Dixon v. Attorney General of the Commonwealth of Pennsylvania, supra; Heryford v. Parker, supra;* see cases cited at note 21 *supra.* See also *Wyatt v. Aderholdt,* 358 F. Supp. 1382 (M.D.Ala.1973) (three-judge court) (sterilization of retarded "cannot be left to the unfettered discretion of any two officials or individuals"). The regulations here codify exactly what the law condemns.

With regard to those over thirteen, the regulations apply only *after* commitment. Any due process must occur *before* an indefinite institutionalization and must provide notice and counsel as well as hearing. See discussion and cases cited *supra* at 67-75. After the child is brought to the hospital, or has been diagnosed by the referring agency, it is unlikely the juvenile will be released.[129]

The regulations do not protect the susceptible juvenile from succumbing to pressures and involuntarily acquiescing in the commitment:

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[129]

> Once the psychiatrist has made a "diagnosis," the patient is considered "sick." The psychiatrist does not have to prove his allegation (in court or outside of it). But the patient must now prove, as it were, that he is "not sick."

Szasz, *Civil Liberties and the Mentally Ill,* 9 Clev-Mar. L. Rev. 399, 407 (1960).



> The fact that a new "patient" may act in a passive manner and not protest should not be taken "to be a meaningful acceptance of commitment."

Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill,* 44 Tex L. Rev. 424, 447 (1966). See *Haley v. Ohio,* 322 U.S. 596 (1948); *In re Gault,* 387 U.S. 1 (1966).

There must be a consultation with an attorney before the juvenile is asked to sign the complex waiver the regulations provide:

> Because young persons usually are more susceptible to persuasion than are older persons, there is a greater danger that they will be more easily induced to commit themselves voluntarily to mental hospitals unless their rights are carefully explained to them by lawyers.

A. Harris, *Mental Illness, Due Process and Lawyers,* 55 A.B.A.J. 65 (1969).[130]

It would be harmful and counter-therapeutic to follow the state's regulations and allow only a post-commitment hearing. As one expert testified:

> I think it is a most inadequate provision and it is closing the barn door after the horse is out. I think it is disastrous to hospitalize a child and then find out, by golly, it wasn't necessary. That is playing with a child's life.[131]

Pennsylvania has revised its commitment law with respect to a *portion* of the plaintiff class. While persons 18 and younger alleged to be retarded are still

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[130]See Testimony of Dr. Messinger at 631a-632a; Dr. Miller at 702a (unauthorized punishment for juvenile requesting attorney).

[131]Dr. Messinger at 631a. See Testimony of Dr. Feiner at 482a and Dr. Ingall at 596a.

committed under the original law and regulations, persons 13 and younger alleged to be mentally ill are committed in a similar fashion[132] under the revised law. Thus, the revised law continues the procedures without change for the great majority of the plaintiff class.[133]

## II.

## THE DISTRICT COURT DID NOT ABUSE ITS DISCRETION IN REQUIRING THE DEFENDANT STATE OFFICIALS TO ASSURE THAT JUVENILES PRESENTLY COMMITTED RECEIVE CONSTITUTIONAL STATE PROCEDURES TO DETERMINE WHETHER THEY ARE MENTALLY DISABLED AND IN NEED OF INSTITUTIONALIZATION.

### A. Preiser v. Rodriguez Does Not Bar Relief for Juveniles Presently Committed.

The complaint herein requested injunctive and declaratory relief[134] to assure constitutional state procedures in the hospitalization of children in mental institutions. Seeking only the guarantee of a state forum in which to have the claims against them determined, the plaintiffs sought from the federal court

[132]The new procedure for the mentally ill is remarkably identical to the former procedure under the regulations.

[133]See note 20 *supra.*

[134]An initial prayer for damages was voluntarily withdrawn early in the litigation.



neither release nor any order with regard to their custody.[135]

The class defined by the complaint and by the District Court[136] included *all juveniles "who have been, are,* or may be" committed upon parental application (emphasis added). Thus, *ab initio,* the plaintiffs have sought relief for those persons presently institutionalized as well as those who may be institutionalized in the future.

In Paragraph 15(E) of its Final Order,[137] the District Court enjoined the defendants to "initiate procedures, commencing immediately, to assure that all children eighteen years of age or younger already admitted or committed" under the challenged laws be provided with the procedures required by the decision.

The defendants object[138] to this portion of the order[139] and argue that it is barred by the principle of

[135]See Complaint at 22a-23a. Individual plaintiffs did allege that they objected to their commitments.

[136]Complaint at 10a-11a; Order of April 29, 1974 at 270a; Opinion, 402 F. Supp. at 1041; 783a; Final Order at 844a.

[137]Paragraph 15(E) is reproduced at 851a.

[138]Despite lengthy prior notice of the broad class definition, and the presence of defendants' counsel in open court when the definition was drafted (255a-256a), the defendants did not object to the possibility of relief for presently confined persons until the very end of the litigation (838a-839a). The District Court never directly ruled on this belated objection but merely issued its Final Order reasserting Paragraph 15 (E) as it appeared in the Proposed Order with certain additions. *Cf.* 832a with 851a-852a. The argument made here in the text presupposes that this Court reaches this issue.

[139]The defendants do not appear to object to any portion of Declaratory Relief granted (844a-848a).

*Preiser v. Rodriguez*, 411 U.S. 475 (1973), and the necessity that plaintiffs seek state habeas corpus relief.

The District Court ordered the defendant state officials to initiate procedures to assure that all juveniles committed without hearings or counsel under the unconstitutional statutes receive the benefit of "accurate fact-finding," *McKeiver v. Pennsylvania*, 403 U.S. 528, 543 (1971), in a state forum.

Appellants' assertion that *Preiser v. Rodriguez*, 411 U.S. 475 (1972), and *Wolff v. McDonnell*, 418 U.S. 539 (1973), bar such relief is based on a misreading of those cases and a failure to note other actions of this Court which support the District Court's order.

*Preiser* and *Wolff* held that litigants could not obtain from the federal courts, in actions under 42 U.S.C. §1983, relief affecting "the fact or duration of confinement" or effecting "immediate or a speedier release."[140] *Wolff* noted that "an injunction restoring good time improperly taken is foreclosed" but specifically permitted federal courts to "fashion appropriate remedies for any constitutional violations ascertained, short of ordering the actual restoration of good time already cancelled."[141]

The District Court faithfully followed *Wolff's* proscription. It did not order "actual restoration" of liberty to plaintiffs and their class; it simply ordered that the defendant welfare department officials assure that proper state proceedings be afforded persons who had never had them. It would be in these state proceedings (not in the federal court) that commitment

[140] *Preiser v. Rodriguez*, 411 U.S. 475, 500 (1973).

[141] *Wolff v. McDonnell*, 418 U.S. 539, 555 (1974).



determinations would be made. The alternative to this orderly process would have been to allow the possibly erroneous commitment of thousands of persons to stand.

This Court's decision in *Gerstein v. Pugh*, 420 U.S. 103 (1975), directly supports the District Court and explains the error in appellants' argument:

> Respondents did not ask for release from state custody, even as an alternate remedy. They asked only that the state authorities be ordered to give them a probable cause determination. This was also the only relief that the District Court ordered for the named respondents. 332 F. Supp. at 1115-1116. Because release was neither asked nor ordered, the lawsuit did not come within the class of cases for which habeas corpus is the exclusive remedy. *Preiser v. Rodriguez*, 411 U.S. 475, 93 S. Ct. 1827, 36 L.Ed.2d 439 (1973); see *Wolff v. McDonnell*, 418 U.S. 539, 554, 94 S. Ct. 2963, 2973, 41 L.Ed.2d 935 (1934).

*Id.* at n. 6.[142] See *Gomez v. Miller*, 341 F. Supp. 323 (S.D.N.Y. 1972), aff'd sub. nom., *Miller v. Gomez*, 412 U.S. 914 (1973) (class action challenging constitutionality of pretrial confinement in state mental hospital for the criminally insane; relief sought and upheld was a state "determination of dangerousness as a prerequisite to retention").

[142] In *Gerstein*, as in this case, persons were deprived of their liberty for a substantial period without a probable cause hearing. The relief granted in *Gerstein*, as in this case, assured constitutional proceedings in a state forum.[143]

[143] See *Hartman v. Scott*, 488 F.2d 1215 (8th Cir. 1973); *Bradford v. Weinstein*, 519 F.2d 728 (4th Cir. 1974), appeal dismissed on other grounds, ___ U.S. ___, 46 L.Ed.2d 350 (1975); *Joyce v. Gilligan*, 383 F. Supp. 1028 (N.D. Ohio 1974); *Winegard v. State of North Carolina*, 366 F. Supp. 983

*(continued)*

Appellants' reliance on *Kendall v. True*, 391 F. Supp. 413 (W.D.Ky. 1975), is misplaced. That case did not consider or discuss the *Preiser* issue. Also, the plaintiff mental patients in *Kendall* were incarcerated under a statute which provided for a maximum hospital term of 60 days and under which a judicial hearing and counsel were provided. Here, the plaintiffs are under an indeterminate term and have had no hearing or counsel.

Defendants further argue that, if it is held that those plaintiffs covered by Paragraph 15(E) must utilize habeas corpus, the exhaustion requirements of 28 U.S.C. §2254(b) would apply.

Section 2254(b)[144] applies only to "persons in custody pursuant to the judgment of a state court."[145]

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*(footnote continued from preceding page)*
(W.D.N.C. 1973); *United States ex rel. Johnson v. Chairman of the New York State Board of Parole*, 363 F. Supp. 416 (E.D.N.Y. 1973).

A Three-Judge Court in Pennsylvania recently became the first to address the *Preiser* issue in the mental health context. *Goldy v. Beal*, ___ F. Supp. ___ (M.D.Pa., July 8, 1976), in enjoining as unconstitutional the state civil commitment law, held that *Preiser* did not bar such relief following the analysis suggested in the text.

[144]This statute is reproduced at Brief for Appellants 59, n.61.

[145]If plaintiffs' Section 1983 claims went "directly" to the propriety of their confinement and sought from the federal court either "immediate release" or a "shortening" of confinement, then under *Preiser* they would be fatally "close to the core of habeas corpus" even though they are not in custody under a state court judgment. *Preiser*, 411 U.S. at 489. However, where no such relief is sought or obtained and where the federal court specifically defers to the state courts to decide the propriety of individuals' confinements, the literal terms of the statute should be held to apply and exhaustion not required.



Plaintiffs were all committed without any involvement of a state court or other adjudicatory body whatsoever.

Section 2254(b) also exempts from its ambit situations where there is an "absence of available State corrective process or the existence of circumstances rendering such process ineffective . . ." Even if each or some of the thousands of institutionalized young people in Pennsylvania could succeed in obtaining counsel to file state habeas petitions, *the petitions would not be heard because, by its very terms, the state habeas corpus statute for mental patients does not apply to plaintiffs.*[146]

Habeas corpus jurisdiction is limited by the state statute to persons committed by a court or under two sections of law not relevant here.[147] 50 P.S. 4426(c). Thus, there is no state corrective process available and effective to protect the plaintiffs' rights; no exhaustion of remedies is required because there are none to exhaust.

Principles of federalism were similarly respected by the District Court. No state proceedings were interfered with; in fact, the state executive, judicial and legislative branches are left free to continue commitment of juveniles, so long as the procedures used do not violate the Constitution.

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[146]The statute, 50 P.S. §4426, is reproduced at Brief for Appellants 8-9 and referred to *ibid* at 59. This statute is repealed by the new Mental Health Procedures Act insofar as it applies to the mentally ill, not the retarded.

[147]Section 404, held unconstitutional in *Dixon v. Attorney General of the Commonwealth of Pennsylvania*, 325 F. Supp. 966 (M.D.Pa. 1971), and Section 405 (emergency "dangerousness" commitments).

Contrary to defendants' dire speculations of "a clash between the federal and state judicial systems," *Brief for Appellants* at 62, those systems worked in concert in this case until the Final Order issued.[148] While the District Court never had the opportunity to rule directly on this federalism issue,[149] it did assure avoidance of any direct conflict as it issued no injunctive relief against the state courts. The interim declaratory relief[150] both respected the integrity of the state judicial system and comported with the extremely broad range of remedies proper upon a finding of constitutional violations, *Hills v. Gautreau,* ___ U. S. ___ (1976). *Cf. Rizzo v. Goode,* 423 U.S. 362 (1975) (no constitutional violation found).[151]

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[148]See discussion at 17 *supra* and letters between the courts at Appendix *infra.*

[149]*Id.* The entire issue, therefore, is one which should not and need not be decided by this Court.

[150]Paragraph 11 of the Final Order (846a).

[151]The District Court, in its opinion and final order, specifically noted its deference to the principles enunciated most recently by this Court in *Rizzo v. Goode,* 423 U.S. 362 (1976). The District Court explained:

> As we have already noted, due process is flexible; the Constitution mandates no specific code of procedures. We are aware of the problems facing courts when they attempt to fashion procedures protecting language of the Fourteenth Amendment and we are sensitive to the claim that courts are "good at deciding cases, bad at drafting legislation. . . ." See, Friendly, J. "Some Kind of Hearing," *supra.* When presented with claims of constitutional dimension, however, we are constrained, when legislative bodies have failed to act, to find means of enforcing the constitutional rights being denied. Our action is not intended to pre-empt the state which is free to develop its own safeguards so long as they are as fully effective as
> *(continued)*



The alternative to requiring this orderly state constitutional process would have been to permit the indefinite and possibly erroneous mental commitments of thousands of persons, all without a state remedy to pursue. The solution adopted by the District Court is well within its power for, "in constitutional adjudication, as elsewhere, equitable remedies are a special blend of what is necessary, what is fair, and what is workable." *Lemon v. Kurtzman,* 411 U.S. 192, 200 (1973) (note omitted).[152]

### B. The District Court's Requirement of Constitutional State Procedures for Persons Presently Committed Does Not Violate the Eleventh Amendment.

The defendants argue that the District Court violated the Eleventh Amendment when it ordered[153] that persons presently incarcerated unconstitutionally be provided state procedures to determine whether they require commitment. In their analysis, the defendants claim that the cost of providing this relief to juveniles

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*(footnote continued from preceding page)*

> those which we set out. See Miranda v. Arizona, 384 U.S. 436, 490, 86 S. Ct. 1602, 16 L.Ed.2d 694 (1966); Morrissey, 408 U.S. at 490, 92 S. Ct. 2593.

Opinion at 800a, n. 16; 402 F. Supp. at 1048-1049, n. 16. The legislature is free to develop an alternate constitutional system. Opinion at 802a, n. 18 and 803a, n. 19; 402 F. Supp. at 1049, n. 18 and 1050, n. 19.

[152]In that case, the Court noted, "In shaping equity decrees, the trial court is vested with broad discretionary power; appellate review is correspondingly narrow." *Id.* (citation omitted).

[153]851a - 852a (Paragraph 15E).

presently incarcerated without hearings may not be imposed on the state.[154] The Eleventh Amendment dictates no such result.

The Eleventh Amendment bars suits by citizens against unconsenting states. *Hans v. Louisiana*, 134 U.S. 1 (1890). However, federal courts have undoubted authority to entertain suits against state officials where they act unconstitutionally. *Ex Parte Young*, 209 U.S. 123 (1908).

In the case at bar, the enforcement of Pennsylvania's commitment law was found unconstitutional. The District Court did not award damages or "equitable restitution" of funds from the state treasury; expenditure of state funds to implement the decree is incidental to the constitutionally mandated goal of assuring that persons are not erroneously incarcerated. This Court has frequently required equitable relief having substantial fiscal impact on a state. Such impact, held *Edelman v. Jordon*, 405 U.S. 651, 667-668 (1974), is not barred by the Eleventh Amendment:

> The injunction issued in *Ex parte Young* was not totally without effect on the State's revenues, since the State law which the Attorney General was enjoined from enforcing provided substantial monetary penalties against railroads which did not conform to its provisions. Later cases from this Court have authorized equitable relief which has probably had greater impact on state treasuries than did that awarded in *Ex parte Young*. In *Graham v. Richardson*, 403 U.S. 365 (1971), Arizona and Pennsylvania welfare officials were

[154]Defendants do not assert that any of the injunctive relief granted by the District Court as to future commitments violates the Eleventh Amendment.



> prohibited from denying welfare benefits to otherwise qualified recipients who were aliens. In *Goldberg v. Kelly*, 397 U.S. 254 (1970), New York City welfare officials were enjoined from following New York State procedures which authorized the termination of benefits paid to welfare recipients without prior hearing. But the fiscal consequences to state treasuries in these cases were the necessary result of compliance with decrees which by their terms were prosective in nature. State officials, in order to shape their official conduct to the mandate of the Court's decrees, would more likely have to spend money from the state treasury than if they had been left free to pursue their previous course of conduct. Such an ancillary effect on the state treasury is a permissible and often an inevitable consequence of the principle announced in *Ex parte Young, supra.*[155]

415 U.S. at 667-668 (note omitted). Surely "equitable restitution" of funds directly to plaintiffs, held in *Edelman* to resemble monetary damages, is a far cry from requiring compliance with procedural due process.

[155]See, *Ad Hoc Committee on Judicial Administration v. Massachusetts*, 488 F.2d 1241, 1243, n 2 (1st Cir. 1973):

> Courts have not limited the Ex parte Young doctrine to "negative" relief, and have often ordered positive governmental action. In cases involving deprivation of constitutionally protected rights, "affirmative" relief has been granted, notwithstanding the fact that the incidental effect is that the states will be forced to expend funds from its treasury. See e.g., *Graham v. Richardson*, 402 U.S. 365, 91 S. Ct. 1848, 29 L.Ed.2d 534 (1971); *Gideon v. Wainwright*, 372 U.S. 335, 83 S. Ct. 792, 9 L.Ed.2d 799 (1963); *Inmates v. Eisenstadt*, 360 F. Supp. 676 (D.Mass. 1973); *Martarella v. Kelley*, 349 F. Supp. 575 (S.D.N.Y. 1972).

*Edelman*, the only case relied on here by defendants, held only that a federal court's remedial power "may not include a retroactive award which requires the payment of funds from the state treasury." 415 U.S. at 677. This decision that a governmental cash benefits program would be disrupted by the drain of additional unallocated welfare benefit payments cannot be read to sanction the State's desire, in this case, to continue to confine in mental institutions, without hearings, thousands of juveniles.

## CONCLUSION

For the above reasons, appellees respectfully submit that the judgment of the District Court should in all respects be affirmed.

Respectfully submitted,

DAVID FERLEGER
*Counsel for Appellees*

August, 1976



## APPENDIX

### UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF PENNSYLVANIA

H. HUYETT, 3RD
JUDGE

12614 UNITED STATES COURTHOUSE
INDEPENDENCE MALL WEST
PHILADELPHIA, PENNSYLVANIA 19106
215-597-9644

September 16, 1975

Honorable Alexander F. Barbieri
Court Administrator of Pennsylvania
Room 317, Three Penn Center Plaza
Philadelphia, Pa. 19102

Re: *Bartley, et al. vs. Kremens, et al.*
*(C.A. No. 72-2272)*

Dear Judge:

As a follow-up of your call to me of the other day, I have talked to the other members of the three-Judge court in the above case and we shall, of course, touch base with you before we hand down a Final Order.

Our case, of course, concerns all persons eighteen years of age or younger who have been admitted or committed to mental institutions in Pennsylvania under the sections of the Act which concerned our three-Judge court.

Judge Gibbons suggested that you might wish to talk to the Administrative Office of the New Jersey Courts in Trenton because sometime ago Chief Justice Hughes required the New Jersey Courts to review every file of every patient of state mental institutions and it may be that the experience of the New Jersey Administrative

Office in that massive undertaking may be helpful to you.

In any event, I shall keep in touch with you.

With kindest personal regards.

Very sincerely yours,

/s/ Dan
Daniel H. Huyett, 3rd

DHH/dr



SUPREME COURT OF PENNSYLVANIA

ADMINISTRATIVE OFFICE OF PENNSYLVANIA COURTS
317 THREE PENN CENTER PLAZA
PHILADELPHIA, PENNSYLVANIA 19102
(215) 567-3071 — 686-3578

EXANDER F. BARBIERI
JUDGE
ADMINISTRATOR OF PENNSYLVANIA

DEPUTY COURT ADMINISTRATORS
CARLILE E. KING, ESQUIRE
GERALD W. SPIVACK, ESQUIRE
ROBERT F. KENT, ESQUIRE

October 14, 1975

RECEIVED
OCT 15 1975

The Honorable Daniel H. Huyett, 3rd
Room 12614
601 Market Street
Philadelphia, Pennsylvania 19106

Dear Judge Huyett:

#72-2272

Re: *Bartley v. Kremens*, #72-2272

Many thanks for your kind letter of September 16, and for efforts on my behalf.

Please thank the other members of your three-judge court for their thoughtfulness.

I like your idea of contacting the New Jersey Administrative Office. Judge Simpson, the judge who manages the New Jersey court systems, is a friend of mine, and we frequently discuss our mutual administrative problems.

Again, many thanks to all of you, and I will await your advices.

Sincerely yours,

/s/ Alex
Alexander F. Barbieri
Court Administrator of Pennsylvania

AFB:ek



SUPREME COURT OF PENNSYLVANIA

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ROBERT F. KENT, ESQUIRE

October 15, 1975

The Honorable Daniel H. Huyett, 3rd
United States District Court
Eastern District of Pennsylvania
United States Courthouse
Sixth and Market Streets
Philadelphia, Pa. 19107

RECEIVED
OCT 17 1975

Dear Judge Huyett:

Re: *Bartley, et al. v. Kremens*
*Civil Action No. 72-2272*

As you know, the Administrative Office of Pennsylvania Courts is extremely concerned about, and sensitive to, Federal Court decisions which impose substantial new hearing burdens on an already overtaxed state judiciary. We deeply appreciate your diligence and cooperation in permitting the Pennsylvania Judicial System, by the Court Administrator, to be involved in the drafting of a final Order in the above

matter, because of the large potential hearing responsibility which the decision places upon our state trial system.

We have talked frequently with the Office of the Attorney General of Pennsylvania, principally through Lawrence Silver, Esquire, and Barry Roth, Esquire, concerning a proposed final Order submitted by them, as well as the draft Order circulated by your Honor within the past several weeks. We understand that all interested parties, including this office, have been requested to submit comments or exceptions to the proposed drafts on or before October 17, 1975 to the Court and to all parties. In compliance with your request, we therefore submit our exceptions to you for your early consideration.

We realize that we are not a formal party to these proceedings and that our involvement must therefore be peripheral. We are anxious to have the Court review our reactions to the *Bartley* Opinion and its practical thrust, and to appreciate some of the administrative difficulties faced by the Pennsylvania Judicial System in gearing up for this newly imposed hearing responsibility. We refer to the concern expressed by the Attorney General of Pennsylvania in his letter to you dated August 21, 1975, wherein at page three it is stated the burden imposed on the Pennsylvania court system is potentially substantial and that our advice should be entertained. We wish to be supportive of the exceptions taken by the Attorney General and add our own as of particular concern to us.

We shall refer to the particular sections of your proposed Order by page and number.



*Page 2, No. 3:* The provision for notice to the child's attorney at least forty-eight (48) hours prior to the initial detention hearing may not give counsel adequate preparation and evaluation time so as to advise fully the Court or "neutral tribunal" of the circumstances of the child's condition and need for admission or, conversely, lack of need for confinement. We suggest that the initial hearing might better be held after several days rather than just three to permit a fuller hearing.

*Page 2, No. 4:* The right to free counsel for indigents must be based upon some objective standard of indigency, that is, whose assets are to be counted, those of parents, or others? Also, Philadelphia County is not included in the statewide Public Defender program as are the other sixty-six counties. Some standard for the entire state might best be written into the Order.

*Page 3, No. 7:* The probable cause hearing after seventy-two (72) hours may not provide sufficient time for preparation and therefore sufficient evidence for proper evaluation by the Court or "neutral tribunal." There may be no opportunity for judicial "thinking time" as to probable cause for institutionalization. We are unsure as to the standard of proof, labeled as "clear and convincing," set forth at No. 6 and the role of the factfinder with respect to it. We would request clarification of this point.

*Page 3, No. 3:* The full commitment hearing after two weeks gives us more reassurance in terms of preparation time and evaluation of evidence, although we are not sure how much more can be adduced in an additional eleven (11) days. Perhaps, the second

hearing should be held two weeks after the first hearing to provide a longer evaluation period. Then, is the standard of proof stricter at this second, more conclusive hearing? If so, how is such a second standard determined?

*Page 4, No. 11:* The use of the state courts is clearly required by the Order, in general terms, until the Legislature designates an "alternate neutral tribunal." The Court Administrator of Pennsylvania has proposed for adoption by the Supreme Court of Pennsylvania a Rule providing for the appointment of a master at each institution, where possible, to hear these matters promptly and efficiently. A copy of the draft Rule is attached.*

*Page 5, No. 14:* The provision for waiver of certain rights by the child to be instutionalized may be too broad, in that informed waiver by children is still an interpretative area of the law. We urge the Court to be aware of, and sensitive to this concern, so that too broad waiver powers are not here granted.

We are aware that perhaps five thousand hearings or more may have to be conducted within the next several months, and are preparing to shoulder that hearing responsibility with full cooperation to your Honorable Court. We do wish, however, to make the burden as administratively and financially palatable as possible for our statewide court system.

We look forward to meeting with you further, if you deem it appropriate, and thank you for your courtesy to date. We earnestly hope that this effort will mark the beginning of formal communication between the

*The draft has not yet been approved by the Supreme Court, and will follow shortly.



Court Administrator on behalf of the Pennsylvania Judicial System and the Federal Court system.

With best regards,

Very truly yours,

Alexander F. Barbieri
Court Administrator of
Pennsylvania

By: Jonothan Vipond, III
Legal Assistant to the
Court Administrator

JV:ml

Enclosure

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF PENNSYLVANIA

DANIEL H. HUYETT, 3RD
JUDGE

12614 UNITED STATES COURTHO
INDEPENDENCE MALL WEST
PHILADELPHIA, PENNSYLVANIA 19
215-597-9644

November 11, 1975

Jonathan Vipond, III, Esquire
Legal Assistant to the
Court Administrator
Administrative Office of
Pennsylvania Courts
317 Three Penn Center Plaza
Philadelphia, Pa. 19102

Re: *Bartley, et al. v. Kremens, et al.*
*(C.A. No. 72-2272)*

Dear Mr. Vipond:

I appreciate very much your October 15, 1975 letter.

I have conferred with Judge Gibbons and Judge Broderick, the other members of the three-Judge court, and I have suggested to them a number of changes in the final Order which they now have under consideration.

I note that you state in your letter that the Pennsylvania judicial system is preparing to implement our opinion and you advise me that the Supreme Court of Pennsylvania has under consideration a rule for the appointment of a master at each institution. The master system, I believe, will be most helpful and certainly expedite the entire procedure in an efficient manner.



I make the following response to the specific comments on pages 2 and 3 of your letter.

*Page 2, No. 3:* The initial detention hearing is only a probable cause hearing that could be conducted by a master or even by a local District Justice. A probable cause hearing involves only a low-level decision and Pennsylvania District Justices as well as attorneys generally throughout the commonwealth have had vast experience in probable cause hearings. The fuller hearing that you suggest is not required at that stage of the proceedings. Also, to modify the 48-hour notice requirement would necessitate an amendment to our opinion which would not appear to be required considering the nature of a probable cause hearing.

*Page 2, No. 4*: You mention that there is a statewide Public Defender program and also, of course, Philadelphia County has its own defender organization. These defender organizations certainly have clear standards as to what constitutes indigency. I respectfully suggest that there is no problem as to a determination for purposes of implementation of our opinion of the meaning of indigency and we as a Federal Court certainly would be extremely reluctant to lay down a standard for the entire state as you suggest, particularly where it does not appear to be required.

*Page 3, No. 7*: As I stated above, the initial detention hearing is only a probable cause hearing and not a full hearing and State Court personnel have had considerable experience with probable cause hearings which generally take place on short notice. In respect to the standard of proof "clear and

convincing", I respectfully suggest that the law of Pennsylvania is clear as to the meaning of these words and that the judicial officer who conducts the full commitment hearing would have no problem.

*Page 3, No. 8:* The initial detention hearing, of course, is only a probable cause hearing. The full commitment hearing is another matter and the standard of proof there is "clear and convincing". I believe the standard of proof at the two different hearings is clear from our opinion and again your suggestion would require an amendment of our opinion which would not seem desirable.

*Page 4, No. 11*: As I mentioned above, I believe that the adoption of a master system would be most helpful and I would hope that the Pennsylvania Supreme Court would adopt the proposed rule.

*Page 5, No. 14*: We have reconsidered our opinion in respect to waiver and your suggestion would require us to amend our opinion in a substantive way which we decline respectfully to do.

I hope that these comments to your suggestions are helpful and certainly I wish to be as cooperative as possible with the Administrative Office of the Pennsylvania Courts.

The fact that a stay has been granted by the Court of Appeals will give you more time to prepare for all that is necessary to implement our opinion and this, of course, may ease the strain on the State judicial system.

Again, I appreciate very much your letter and your suggestions and I intend to call Judge Barbieri to make



sure that he is satisfied that I have covered all of the points which require discussion at this time.

With kindest personal regards.

Very sincerely yours,

/s/ Daniel H. Huyett, 3rd
Daniel H. Huyett, 3rd

DHH/dr
cc to Hon. John J. Gibbons
Hon. Raymond J. Broderick

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF PENNSYLVANIA

DANIEL H. HUYETT, 3rd
JUDGE

12614 UNITED STATES COURTHOUSE
INDEPENDENCE MALL WEST
PHILADELPHIA, PENNSYLVANIA 19106
215-597-9644

November 17, 1975

Honorable Alexander F. Barbieri
Judge, Court Administrator of
Pennsylvania
317 Three Penn Center Plaza
Philadelphia, Pa. 19102

Re: *Bartley, et al. vs. Kremens, et al.*
*(C.A. No. 72-2272)*

Dear Judge Barbieri:

As you and I discussed by telephone today, I enclose a copy of the Order of the three-Judge court which was handed down today along with a copy of a stay of October 30, 1975 of the Court of Appeals for the Third Circuit which appears to stay our Order pending action by the United States Supreme Court.

Also, as I mentioned to you in our conversation, counsel for plaintiff called my office today and said that he believes that the stay of the Court of Appeals is ambiguous and he will seek a clarification from the Court of Appeals.

It is necessary for the three-Judge court to hand down its Order since the United States Supreme Court



cannot act without a final order of the three-Judge court.

I shall, of course, keep you fully advised.

Very sincerely yours,

/s/ Dan
Daniel H. Huyett, 3rd

DHH/dr
Enclosures
cc to Honorable John J. Gibbons
Honorable Raymond J. Broderick

P.S. to Judges Gibbons and Broderick: Enclosed are two fully conformed copies of our November 17, 1975 Order.

D.H.H.

SUPREME COURT OF PENNSYLVANIA

ADMINISTRATIVE OFFICE OF PENNSYLVANIA COURTS
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DEPUTY COURT ADMINISTRATORS
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GERALD W. SPIVACK, ESQUIRE
ROBERT F. KENT, ESQUIRE

November 20, 1975

RECEIVED
NOV 24 1975

The Honorable Daniel H. Huyett, 3rd
United States District Court
Eastern District of Pennsylvania
12614 United States Courthouse
Independence Mall West
Philadelphia, Pa. 19106

Dear Judge Huyett:

Re: *Bartley, et al. v. Kremens, et al.*
*(C.A. No. 72-2272)*

I very much appreciate your comprehensive response to my letter of October 15, 1975 setting forth various comments and suggestions with respect to a proposed Order in the above matter. Both Judge Barbieri and I do appreciate your extreme courtesy and earnestly hope that this marks the beginning of a fully cooperative relationship between the Federal Court system and the Administrative Office of Pennsylvania Courts.



Judge Barbieri and I have subsequently received your Final Order and have reviewed it. The Supreme Court has not yet formulated a rule to implement your Order and is most concerned about the gargantuan burden about to be placed on the court system of Pennsylvania. I believe that my earlier letter to you merely recognized the potential responsibility which your opinion and Order place on the State Judiciary and did not set forth our willingness or practical ability to shoulder the burden. A rule may yet be adopted but the Supreme Court simply does not have the present manpower and fiscal resources to conduct between five and eight thousand hearings. We wish to be cooperative to the maximum extent, but cannot perform the impossible.

We look forward to continued discussions with you in the further disposition of this case.

With best regards.

Very truly yours,

Alexander F. Barbieri
Court Administrator of
Pennsylvania

By: Jonathan Vipond, III
Legal Assistant to the
Court Administrator

JV:ml

cc: Norman J. Watkins, Esq.
The Honorable Alexander F. Barbieri

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF PENNSYLVANIA

DANIEL H. HUYETT, 3rd
JUDGE

12614 UNITED STATES COURTHOUSE
INDEPENDENCE MALL WEST
PHILADELPHIA, PENNSYLVANIA 19106
215-597-0644

November 25, 1975

Jonathan Vipond, III, Esquire
Legal Assistant to the Court
Administrator
Administrative Office of
Pennsylvania Courts
317 Three Penn Center Plaza
Philadelphia, Pa. 19102

Re: *Bartley, et al. vs. Kremens, et al.*
*(C.A. No. 72-2272)*

Dear Mr. Vipond:

I appreciate very much your November 20, 1975 letter.

Very sincerely yours,

/s/ Daniel H. Huyett, 3rd
Daniel H. Huyett, 3rd

DHH/dr



SUPREME COURT OF PENNSYLVANIA

ADMINISTRATIVE OFFICE OF PENNSYLVANIA COURTS
317 THREE PENN CENTER PLAZA
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ALEXANDER F. BARBIERI
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DEPUTY COURT ADMINISTRATORS
CARLILE E. KING, ESQUIRE
GERALD W. SPIVACK, ESQUIRE
ROBERT F. KENT, ESQUIRE

November 26, 1975

RECEIVED
DEC 1 1975

The Honorable Daniel H. Huyett, 3rd
Room 12614, 601 Market Street
Philadelphia, Pennsylvania 19106

Dear Judge Huyett:

Re: *Bartley v. Kremens*

I have just read over the file in this matter, and find that Jon Vipond has expressed the view that a rule of court might be requested of our Supreme Court by this Office.

I think it only fair to advise you that no such rule has been authorized or is presently being contemplated by the Supreme Court. It was a cooperative suggestion of Mr. Vipond, and one that I had considered a possible expedient, if any effort was to be made to implement your order.

Since your order is on appeal, and since our study of your recent order indicates that it contains directives

which would require judicial or other action by our courts, which would be contrary to law in Pennsylvania, it will be necessary for this Office to join in the appeal. We will also join in objections advanced by the Attorney General, adding others of our own that stem from the incapability of the judicial system of Pennsylvania to comply.

Very truly yours,

/s/ A. F. Barbieri
Alexander F. Barbieri
Court Administrator of Pennsylvania

AFB:ek

Supreme Court, U. S.
FILED
NOV 22 1976
MICHAEL RODAK, JR., CLERK

# In the Supreme Court of the United States

No. 75-1064

JACK B. KREMENS, Individually and as Hospital Director of Haverford State Hospital; FRANK S. BEAL, Individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; WILLIAM B. BEACH, JR., Individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,

Appellants

v.

KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND; Minors, Through Their Next Friend, Individually and on Behalf of All Others Similarly Situated,

Appellees

Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania.

## REPLY BRIEF FOR APPELLANTS

NORMAN J. WATKINS
Deputy Attorney General

BARRY A. ROTH
Assistant Attorney General

J. JUSTIN BLEWITT, JR.
Deputy Attorney General
Chief, Civil Litigation

ROBERT P. KANE
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Department of Justice
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# REPLY BRIEF FOR APPELLANTS

## ARGUMENT

### I. This Case Should Be Decided on the Merits

On July 9 of this year the Mental Health Procedures Act was enacted,[1] establishing revised procedures for the commitment of emotionally ill persons in Pennsylvania. However, this act does not apply to the mentally retarded and therefore affects only a small portion of the plaintiff class.[2] Moreover, with respect to the mentally ill, the only change in the law relevant to this appeal is that the age below which a mentally ill child can be voluntarily admitted by his parents has been lowered from eighteen years to fourteen.[3]

---

[1] Act of July 9, 1976, P.L. ——, No. 143 (hereafter referred to as the "new act", or "Act 143"). The relevant portions of this Act have been set out in Appellees' Brief (hereafter "App. Br.") at pages 2-5.

[2] Approximately 80% of the plaintiff class is comprised of mentally retarded children. In fact, as of June 30, 1976, of the 4996 juveniles receiving inpatient treatment in Pennsylvania institutions, as the result of voluntary placements, only 1209 were mentally ill (310a et seq.—current census).

[3] There has been no real change in the law with respect to who is authorized to challenge the validity of a mentally ill child's commitment. 50 Pa. Stat. Ann. §4426(a) authorizes the child ". . . or anyone acting on his behalf . . ." to challenge the commitment, and the Mental Health Procedures Act provides

1. This appeal is not moot. On April 29, 1975, the lower court properly certified this as a class action. The plaintiff class was defined as comprising ". . . all persons eighteen years of age or younger who have been, are or may be admitted to mental health facilities in Pennsylvania pursuant to the challenged provisions of the state mental health law (i.e., 50 P.S. §§4402 and 4403)" (270a).[4] When the class was certified the named plaintiffs were all under eighteen years of age and receiving inpatient treatment in a mental health facility pursuant to the specified provisions of the 1966 Act. Thus, these individual plaintiffs were in fact members of the class when it was certified, and therefore remain proper representatives of that class, despite the fact that their individual claims may have become moot by the subsequent enactment of this legislation.[5] *Franks v. Bowman Construction Co., Inc.*, 424 U.S. 747 (1976). *Sosna v. Iowa*, 419 U.S. 393 (1975).

Sections 402 and 403 of the Mental Health and Mental Retardation Act of 1966 presently apply, and in fact are being applied, to the vast majority of the unnamed plaintiffs. And, those who are still subject to the challenged portions of the 1966 Act obviously continue to have a live controversy with the defendants. *Franks v. Bowman Construction Co., Inc., supra, Sosna v. Iowa, supra, Gerstein v. Pugh*, 420 U.S. 103 (1974), *Richardson v. Ramirez*, 418 U.S. 24 (1973), *Dunn v. Blumstein*, 405 U.S. 330 (1972).[6]

---

that ". . . any responsible party" may contest the child's placement, Sec. 206(b) (App. Br. 4). Nor have any additional procedural protections been supplied by the new act for mentally ill children under fourteen years of age.

[4] No issue has been raised in this appeal regarding the propriety of that class certification.

[5] Moreover, certain mentally retarded plaintiffs specifically identified by the court are not affected in the least by the new law (789a-790a).



2. This case should not be remanded to the district court for consideration of the Mental Health Procedures Act. Over three-fourths of the plaintiff class, mentally retarded juveniles, are subject to the very statutes which the lower court examined, declared unconstitutional, and enjoined.[7]

Additionally, the due process issue has not changed in the least for emotionally ill children under fourteen years of age. In Act No. 143 the Pennsylvania General Assembly, in disagreement with the majority below, has provided those children with none of the protections man-

---

[6] Lower courts, as well, have uniformly recognized that a case does not become moot simply because the class representative may have had his claim settled, provided that a live controversy exists between unnamed members of the class and the defendants; *Valentino v. Howlett*, 528 F.2d 975 (7th Cir. 1976); *Allen v. Likins*, 517 F.2d 532 (8th Cir. 1975); *Ramer v. Saxbe*, 522 F.2d 695 (D.C. Cir. 1975); *Troy v. Shell Oil Co.*, 519 F.2d 403 (6th Cir. 1975); *Jones v. Diamond*, 519 F.2d 1090 (5th Cir. 1975); *Doe v. Mundy*, 514 F.2d 1179 (7th Cir. 1975); *Frost v. Weinberger*, 515 F.2d 57 (2nd Cir. 1975); *Taylor v. St. Vincent's Hospital*, 523 F.2d 75 (9th Cir. 1975); *National Broadcasting Co. Inc. v. F.C.C.*, 516 F.2d 1101 (D.C. Cir. 1974).

Compare: *Hall v. Beals*, 396 U.S. 45 (1969), *Board of School Commissioners of the City of Indianapolis v. Jacobs*, 420 U.S. 128 (1975), and *Weinstein v. Bradford*, 423 U.S. 147 (1975); each of which was either not brought, or not effectively certified as a class action.

[7] The stay granted on December 16, 1975 allows the continued use of Sections 402 and 403 of the 1966 Act, as well as the regulations promulgated thereunder, 423 U.S. 1028-9 (1975).

dated in this case. Juveniles, whether by §402 and §403 of the 1966 Act, or §201 of Act 143, may still be committed to a Pennsylvania mental health facility solely on the basis of the joint decision of the parent and physician. Thus, in all relevant respects both Acts are identical, and the district court has already clearly expressed its view that this scheme is unconstitutional.[8] There is, therefore, nothing additional in the way of procedural protections for children in the new act for the lower court to consider on remand. *National Independent Coal Operators Association v. Kleppe*, 423 U.S. 388, 393-4 n. 4 (1975).

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## II. The Merits: Admission of Children to Pennsylvania Mental Health Facilities

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It is relatively difficult to secure in-patient psychiatric services in a Pennsylvania mental health facility. And, in some respects the difficulties are compounded when parents seek these services for their children.[9] For

[8] Appellees correctly point out that the district court was in fact made aware of the possibility that the Legislature might reduce the age for voluntary admissions from eighteen years to fourteen (240a-241a, 654a). However, this change with respect to the emotionally ill obviously did not satisfy the court's objections to the procedure. Similarly, the court specifically analyzed and rejected the regulations set out at pages 9-15 of Appellants' Brief (236a-250a, 504a, 556a-558a, 598a).

[9] The record in this case shows that, with respect to the mentally retarded, the admission process for children is usually initiated by the child's parents or other responsible family member. Of the total admissions, nearly 75% were sought by the parents or, where appropriate, another relative (224a, 225a).



example, the defendants' regulations require an additional medical examination prior to a child's admission as compared to the admission of an adult. The regulations also impose a broad array of procedural measures for children over age thirteen (Appellants' Brief, pp. 12-15). For these and other obvious reasons parents are generally reluctant to seek inpatient psychiatric care for their children.[10] Nonetheless, like other public health delivery systems, the need for these services is much greater than the supply.[11]

Notwithstanding these considerations, the plaintiffs have argued that children are often whimsically admit-

[10] "Parents are often even more frightened than their teenage child by the prospect of admission." Shade, R. H., *Parental Resistance to Hospital Treatment of Adolescents*, 4 Adolescence 512, 514 (1969).

[11] The President's Committee on Mental Retardation has noted that ". . . since most public institutions operate at or above capacity, the delay between applying for and gaining admission is usually great. Often it is more than three years." President's Committee on Mental Retardation, *Changing Patterns in Residential Services for the Mentally Retarded*, at 17 (1969).

Nationally there has been a decrease in the number of residents under age eighteen receiving inpatient services in state and county mental hospitals each year since 1971. Department of Health, Education and Welfare, NIMH, *Statistical Note 113, State Trends in Resident Patients—State and County Mental Hospital In-Patient Services 1967-1973*, 1 (Feb., 1975). A similar decrease has been noted in Residential treatment of retarded juveniles, National Association of Superintendents of Public Residential Facilities for the Mentally Retarded, *Current Trends and Status of Public Residential Services for the Mentally Retarded: 1974*, 53 (1975).

ted [12] to mental health facilities. The mentally retarded, they asserted ". . . often find themselves in institutions through fortuitous and avoidable circumstances" (App. Br., p. 42).

The plaintiffs discussed two specific cases in support of this contention, and selected portions of the patients' records were relied upon (App. Br., pp. 42-43). However, in these purported examples of inappropriate admissions, the plaintiffs looked only to the "reason for placement" and did not note the medical diagnoses of these children.

For example, the plaintiffs correctly noted that the first child's records indicated that the additional familial burdens which were created by the arrival of infirm grandparents on the family scene was noted a "reason for placement" (351a). But, plaintiffs chose to ignore the medical condition of this child:

*Diagnosis* (October 1, 1963):

AAMD

Mental Retardation associated with Encephalopathy due to anoxemia at birth
Visual handicap

[12] However, it has been noted that "[o]f all referrals made to residential centers, only 15 to 20% are accepted, with the majority of referrals not accepted, interestingly enough, on the basis that residential treatment is not indicated. Other reasons for nonacceptance of the referral are unavailable space, center policy, and inappropriate age." Sonis, M, "Residential Treatment", Freedman, ed. *Comprehensive Textbook of Psychiatry*, Williams and Wilkins, Baltimore (1967) at 1475.



Hearing handicap
Major motor seizures
Choreoathetosis
Spastic quadriplegic

APA

Chronic Brain Syndrome associated with birth trauma (anoxemia due to cord being wrapped around neck)
Mental deficiency (x [4])—Severe
(Patient No. 00067-382a)

In their second case, the plaintiffs conjectured that the parents sought inpatient care for their child ". . . to avoid providing their child with birth control, and in order to evade a responsible relative who opposed the child's commitment . . ." (App. Br., p. 43). Plaintiffs' grim account once again failed to consider the medical condition of that child.

*Diagnosis* (December 27, 1963):

AAMD

Mental retardation associated with encephalopathy due to anoxemia at birth
Spastic paraplegia
Level II—Adaptive Behavior—Trainable

APA

Chronic Brain Syndrome due to unknown cause without qualifying phrase
Mental deficiency (x [4])—Severe

*Reevaluated diagnosis* (March 18, 1974):

AAMD

Trauma or physical agent—perinatal hypoxia
Hydrocephalus, secondary
Spasticity with paraplegia, moderate
Adaptive Behavior—Level III (1973 Revised Classification)
(Patient No. 00144—353a) [13]

The point of all this is quite obvious. The propriety of inpatient psychiatric care for a child must be measured primarily against the medical needs of that child. The various concerns the child's parents may have expressed during the admission process may be of some importance to the physician in determining how best to treat those needs—but they clearly are not, and should not alone be controlling.

This seemingly self-evident proposition was made very clear by Dr. Levon D. Tashjian in testimony given in this case (650a). Unfortunately, however, the lower

[13] In this example, as with the first, the plaintiffs relied exclusively on the section of the summarized patient records entitled "reasons for placement".

00144 (Patient number)—Reason for Placement:

"The father described her as hyperactive, but the mother disagreed and said that she was only active. Though the parents stated that she was well accepted at home, they felt that now that she is entering pubescence, it will be better for her to be admitted at this time. The maternal aunt who had been caring for her was away and since she was the one against placement, the parents felt that this was the time to arrange for placement. The brothers, though they love ————, are uncomfortable in her presence" (353a).



court, like the plaintiffs, chose to rely on a distorted picture of the facts surrounding the admissions of these children to Pennsylvania facilities. [14] This error in large part provided the basis for the opinion in this case and therefore necessitates its reversal.

## III. The Remedy of Habeas Corpus Is Available to the Plaintiffs

The right of a mental patient to seek release from custody by habeas corpus is firmly established in Pennsylvania. Section 4426 of the Mental Health and Mental Retardation Act of 1966 provides that the remedy is available to "[e]very person committed or detained in a facility by reason of the provisions of this act . . ." 50 Pa. Stat. Ann. §4426 (set out at pp. 8-9 of Appellants' Brief).

Nevertheless, plaintiffs argue that this broad language does not extend to admissions of juveniles under Sections 402 or 403 of the Act (App. Br., p. 83). The argument is based upon a misreading of the statute. The plaintiffs contend that the inclusion in §4426(c)(1) of specific jurisdiction and venue requirements for challenging commitments under Sections 404 and 405 of the Act makes habeas corpus unavailable to test admissions pursuant to other sections of the Act.

[14] Rather than examining the medical records of all juveniles as suggested by the defendants (288a-289a) the lower court chose only to admit the medical records of ten randomly selected patients (522a, 650a). After having done this, however, the court then apparently ignored these records and based its conclusions on the "reasons for placement" alone (789a-790a).

The inclusion of specific jurisdiction and venue provisions in §4426 is an exception to the general habeas corpus jurisdiction and venue rules which are set out in the Act of May 25, 1951, P.L. 415; 12 Pa. Stat. Ann. §1901. Thus, the Legislature provided in §4426 that ". . . except as hereinafter provided, said petition [for writ of habeas corpus] shall be filed in accordance with the provisions of the Act of May 25, 1951 (P.L. 415)." Therefore, sections challenging any admissions or commitments other than those specified in §4426 must be filed pursuant to the general rules set forth in the 1951 Act:

> "Any judge of a court of common pleas within this Commonwealth shall have jurisdiction at any time, to issue a writ of habeas corpus upon application by, or on behalf of, any person (hereafter called the relator) alleged to be unlawfully imprisoned or detained in any penitentiary, prison, reformatory, house of detention, *mental institution,* or other place, (a) within the judge's judicial district, or (b) outside of his judicial district, if the relator was committed by action of any court of the judge's judicial district: Provided, That when relator's detention or confinement is by virtue of sentence after conviction for a criminal offense, only a judge and the judicial district of conviction and sentencing shall exercise such jurisdiction." 1951, May 25, P.L. 415, §1. (Emphasis added.)

Finally, the Supreme Court of Pennsylvania has noted that, over and above this statutory remedy, a very broad common-law right of habeas corpus has always existed in Pennsylvania.

> ". . . 'It (common law habeas corpus ad subjiciendum) has a much broader scope than that form of it which is secured by the Habeas Corpus Act; for it may issue in all sorts of cases where it is shown to the court that there is probable cause for believing that a person is restrained of his liberty unlawfully or against the due course of law' ". *Com. ex rel. Levine v. Fair,* 394 Pa. 262, 278 (1958); quoting *Williamson v. Lewis,* 39 Pa. 9, 29 (1861).



The plaintiffs had both a statutory and common-law right to test the legality of their confinement by seeking a writ of habeas corpus. They chose to ignore this remedy seeking redress instead under the Civil Rights Act. Therefore, at a minimum, this Court's holding in *Preiser v. Rodriguez,* 411 U.S. 475 (1973), requires reversal of the retroactive portions of the lower court's order alternatively requiring the plaintiffs' release.

## CONCLUSION

On the basis of the foregoing arguments and authorities, as well as those contained in the main brief for Appellants, defendants seek reversal of the decision of the lower court.

Respectfully submitted,

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No. 75-1064

# In the Supreme Court of the United States

OCTOBER TERM, 1975

JACK B. KREMENS, Individually and as Hospital Director of Haverford State Hospital; FRANK S. BEAL, Individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; WILLIAM B. BEACH, JR., Individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania, *Appellants*,

v.

KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND; Minors, Through Their Next Friend, Individually and on Behalf of All Others Similarly Situated, *Appellees*.

## Amicus Curiae Brief in Support of Appellants

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v.

KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND; Minors, Through Their Next Friend, Individually and on Behalf of All Others Similarly Situated, *Appellees*.

## Amicus Curiae Brief in Support of Appellants

### I. Interest of Amicus

The state of Kansas sponsored by its Attorney General herein as an *amicus curiae* has statutory procedures for the voluntary admission of minors which are somewhat similar in scope to the Pennsylvania Mental Health and Mental Retardation Act of 1966, Sections 402, 403, and 426 in question in the above captioned matter. Also similarly, the Kansas procedures apply to admissions to private mental facilities as well as to state operated facilities.

Certainly no state should desire the unnecessary denial of rights or confinement of any of its citizenry

whether juvenile or adult. But with equal certainty no state should advocate the unnecessary extension of its judicial or police powers to disrupt family decisions of medical treatment for its children without an equally apparent benefit or protection to the child, family or society within that state. And with equal certainty no state should be forced to endure the disregarding of the separation of its branches of government and the breaching in abstentia of the immunities of those branches.

The *amicus* thus feels compelled to advise this Court of its position in favor of the Appellants' prayer that the decision of the lower court be reversed.

## II. Questions Presented

This brief is confined to the following issues which the *amicus* considers to be the most crucial to its interests:

(1) Whether injunctive relief ordering or assuming actions of the legislative and judicial branches of a state government may be properly granted when only officials of the administrative branch of that state government are defendant parties in the matter before the Court.

(2) Whether a due process proceeding is a proper and complete substitute for parental and juvenile discretion in choosing mental facility inpatient treatment.



## III. Argument

### A. The Injunctive Relief Granted by the Lower Court Is Improper as Being an Improper Joinder of Remedies, as Being Directed Against Entities Neither Named nor Proper Parties to the Matter and as Being Violative of the Principles of the Separation of Powers.

The injunctive relief ordered by the lower court (Appendix to Jurisdictional Statement, pp. 103a-108a) is apparently a class action and prospective *habeas corpus* order upon that court's newly fashioned procedures and suddenly appended to a 42 U.S.C. §1983 civil rights action. It would be unduly simple, although probably correct, to state that such a joinder of remedies is improper in view of this Court's decision in *Preiser v. Rodriguez*, 411 U.S. 475 (1973). Indeed, the injunctive relief seems premised on the very assumptions discarded by this Court in the *Preiser* decision. The lower court apparently assumes that exhaustion of the state's release procedures or of *habeas corpus* proceedings is unnecessary without even formally considering such proceedings on the further assumption that such proceedings are inadequate and in need of proscription from the lower court. This hurried proscription is suddenly merged into a 42 U.S.C. §1983 action which originally included pleadings for monetary damages (see Appendix to Jurisdictional Statement, p. 16a) and by its very nature tends to involve more time than *habeas corpus* proceedings (see *Preiser v. Rodriguez*, 411 U.S. at 496).

In a larger sense the injunctive orders of the lower court seem to be painted by a broad brush which

obliterates many of the due process principles elsewhere contained in that opinion. The opportunity to be heard which is so carefully accorded to the children seems to be denied to their states. The named defendants of the matter are merely persons as individuals and as officials of the Department of Public Welfare or of the executive branch of the Commonwealth of Pennsylvania (see Ap. to J. S., pp. 1a, 4a, 5a-6a). Neither named nor brought in as parties are the commonwealth itself or its judicial and legislative branches of government. Yet powers and actions of these governmental branches are integral elements of the injunctive orders. The state judicial branch is to be notified of the order, is expected to conduct hearings pursuant to the order, and is to be reported on as to the progress of the hearings. The state legislature is expected to fund the increased obligations of those hearings. Indeed, the lower court blatantly acknowledges that it is acting in the legislative realm as it proclaims: "Until the legislature establishes some other procedure consonant with our opinion and order . . . " (see Ap. to J. S., p. 103a, see also p. 100a).

If the lower court considered the state judiciary and legislature so necessary to the adjudication of the matter, it could perhaps have joined them as parties on its own motion. See *Dungan v. Sawyer*, 250 F.Supp. 480 (1965). This was not done.

Surely it was not considered that an appearance of the state attorney general for named defendants or pursuant to 28 U.S.C. §2284(2) implies an entry of



appearance to waive the specific protections to the state of the Eleventh Amendment of the Constitution of the United States. As recently reiterated by this Court in *Edelman v. Jordan*, 415 U.S. 651 (1974):

> Constructive consent is not a doctrine commonly associated with the surrender of constitutional rights, and we see no place for it here. In deciding whether a State has waived its constitutional protection under the Eleventh Amendment, we will find waiver only where stated "by the most express language or by such overwhelming implications from the text as will leave no room for any other reasonable construction." [415 U.S. at 673, quoting from *Murray v. Wilson Distilling Co.*, 213 U.S. 151, 171 (1909).]

It may also be questionable whether a state may be a proper party defendant in a 42 U.S.C. §1983 suit as a state may not be a "person" within the purview of that act. See *United States ex rel. v. Philadelphia*, 413 F.2d 84 (1969) and *Monroe v. Pape*, 365 U.S. 167 (1961).

The powers of judicial review of the federal judiciary have been recognized by this Court from early in this nation's history as being extensive.

> It is emphatically the province and duty of the judicial department to say what the law is. Those who apply the rule to particular cases, must of necessity expound and interpret that rule. [*Marbury v. Madison*, 1 Cranch 137, 177 (1803).]

And the limits of that power are formed from the same constitution from which it derives.

> Thus, the particular phraseology of the constitution of the United States confirms and strengthens the principle, supposed to be essential to all written constitutions, that a law repugnant to the constitution is void; and that courts as well as other departments are bound by that instrument. [*Marbury v. Madison*, 1 Cranch at 179.]

Among the basic provisions and doctrines of the Constitution is that of separation of powers.

> This Court has not hesitated to enforce the principles of separation of powers embodied in the Constitution when their application has proved necessary for the decisions of cases and controversies properly before it. [*Buckley et al. v. Valeo, Secretary of the United States Senate, et al.*, . . . U.S. . . ., 44 Law Week 4127 (Jan. 27, 1976).]

The *Buckley* decision also cites The Federalist Nos. 47 and 51 by Madison (The Federalist, G. P. Putnam's Sons ed. 1889) as to the importance of the separation of powers doctrine in the framing and the adoption of the Constitution. Implicit in The Federalist No. 47 is the recognition that the states in varying degrees had implemented that doctrine before the adoption of the Constitution. And the states did not surrender that doctrine with the adoption of the Constitution. [See Art. IV §4 of the Constitution of the



United States guaranteeing "every State in this Union a Republican Form of Government . . ." Note again The Federalist No. 47 indicating the importance of the separation of powers for the retention of such a form of government. See also Amendment X of the Constitution of the United States and R. A. Rutland, The Birth of the Bill of Rights 1776-1791 (1955).]

An order misdirected towards officials of only one branch of state government and involving powers and functions of another branch of state government is surely violative of the principles of separation of powers. See *Red Bird v. Berry*, 371 F. Supp. 727 (1973). Such an order must necessarily be constructed on the faulty base of anticipation of what the missing governmental branches may do and on an incomplete presentation of the issues. See *Younger v. Harris*, 401 U.S. 37 (1971) and *Communist Party v. S.A.C. Board*, 367 U.S. 1 (1961).

The lower court's injunctive order attempts to impart state administrative officials with responsibilities over the judicial and legislative branches. That order could direct the performance of ministerial duties by the defendants, but surely it cannot enlarge those duties or borrow powers from other governmental branches. See *Board of Liquidation v. McComb*, 92 U.S. 531, 541 (1875). The defendants are not shown to have any close official connections to the operations, funding and legislation of civil procedures for the state judiciary. The jurisdictional limitations indicated by this Court in *Fitts v. McGhee*, 172 U.S.

516 (1899) and as more fully defined in *Ex Parte Young*, 209 U.S. 123, 156-158 (1908) would seem to deny jurisdiction for such an injunctive order. The *Fitts* decision did indicate that "exceptional or extraordinary circumstances" (172 U.S. at 533) could arise to temper the reasoning, but this case does not seem divorced from previously compelling cases which were able to recognize state separation of powers principles.

For example, the *Goldberg v. Kelly*, 397 U.S. 254 (1970) decision did not place major administrative or financial burdens upon agencies, branches, or persons other than those involved as parties to the matter. Nor did the *Miranda v. Arizona*, 384 U.S. 436 (1966) decision. Even in the decision of *Gideon v. Wainwright*, 372 U.S. 335 (1963), affecting the procedures of Florida and of other states in not providing counsel for indigent criminal defendants, this Court's reversal and remand of the matter did not find it necessary to distort the state *habeas corpus* provisions—in a matter arising on an appeal of a denial of relief in *habeas corpus*. [See the remanded proceedings in *Gideon* in 153 So.2d 299 (1963).]

Surely the newly proclaimed rights of children are not superior to or violative of other constitutional protections.

**B. The Lower Court's Holding that Parents May Not Waive the Constitutional Rights of Their Minor Children as to Mental Facility Treatment Is Novel and Misapplied.**

The determinations of the lower court attempts to find and protect new rights of minor children by



diminishing parental rights and obligations and by increasing the involvements of the state. The parental rights to raise one's children so extensively recognized in this Court's decision of *Stanley v. Illinois*, 405 U.S. 645, 651 (1972) are reduced for a continuing and pervasive state intervention of the very nature which was looked upon with disfavor in *Stanley, supra.*

The clear effect of the opinion and order of the lower court is to destroy the concept of voluntary admissions or commitments of juveniles to mental health facilities, both public and private. The primary reasons for such actions seem based upon the loss of liberty and the stigma often attached to treatment at such facilities (Ap. to J. S., p. 34a n. 8). The prescription of a full set of commitment hearings may be more harmful and disruptive than the previous ills. Social stigma is hardly lessened by a required set of judicial hearings almost guaranteed to resemble criminal or delinquency proceedings [see *Heryford v. Parker*, 396 F.2d 393, 396 (1968).]

As noted in the concurring opinion in *Griswold v. Connecticut*, 381 U.S. 479 (1965):

> In determining which rights are fundamental, judges are not left at large to decide cases in light of their personal and private notions. Rather, they must look to the "traditions and [collective] conscience of our people" to determine whether a principle is "so rooted [there] . . . as to be ranked as fundamental." *Snyder v.*

*Massachusetts*, 291 U.S. 97, 105. (381 U.S. at 493.)

This Court recognized in *Meyer v. Nebraska* [262 U.S. 390, 399 (1923)] . . . that the right "to marry, establish a home and bring up children" was an essential part of the liberty guaranteed by the Fourteenth Amendment. (381 U.S. at 495.)

The opinion of the lower court seems to employ the novel presumption that parents will abuse those rights because of a conflict of legal interests. The proposed procedures would cure that conflict by essentially removing the rights of the parent and not actually increasing the rights of the child, but rather increasing the intervention of the state through its judiciary. During the proposed hearings the child is cut off from parental decisions and guidance as to his rights. The only proscribed rights of the parents in the process is that they "may initiate the temporary detention of a child eighteen years of age or younger in a mental health or mental retardation facility if the procedures and requirements of our opinion and order are fully complied with" (Ap. to J. S., p. 101a). The child is not allowed to waive any of the so-called rights and the full hearing process without the acceptance of the neutral tribunal (Ap. to J. S., p. 102a). In essence that tribunal becomes the custodian of the former parental powers of waivers or rights. The child is still without a direct or unfettered ability to accept or reject the facility detention. And because the lower court does not accord any right or access of appeal



from the decisions of that tribunal, it is equally, if not more, the unchecked arbiter of the child's rights than were his parents. So the premise of the lower court's order becomes not just a check on potential parental abuses but that substitution of a judicial tribunal for parental authority is desirable because due process is per se more desirable than parental discretion.

This is not a contention that children should have no rights or remedies against parental abuse, nor that children should not have rights or access to counsel [see *In re Gault*, 387 U.S. 1 (1967)] or some form of ombudsman or medical review as a protection against abuses. But it is a contention that a greater concern that the lower court's order creates an undue and unwarranted extension of the state's police powers to grossly interfer with parental decisions before such individual decisions are even contended to be harmful to the child. See *Lochner v. New York*, 198 U.S. 45, 49 (1905) and *Wisconsin v. Yoder*, 406 U.S. 205 (1972). In the well chosen words of the dissent of the lower court opinion it does seem that the lower court has ordered a compulsory "overdose of due process" which is not beneficial to the parents or the children. (See Ap. to J. S., p. 52a.)

## IV. Conclusion

Even if it were assumed *arguendo* that parents could not waive or determine the rights of their minor children as to mental facility inpatient treatment, the

forced intervention of non-party state branches of government would remain an improper violation of numerous constitutional guarantees. And an adversary proceeding forced between parent and child is conducive to neither the best protections of the child's rights nor the sheltering of the child from social stigma. In view of these implications, the *amicus* urges this Court to reverse the decision of the lower court.

June, 1976.

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## PROLOGUE

"The democratic faith is this: that the most terribly important things must be left to ordinary men —the mating of the sexes, the rearing of the young, and the laws of the state. This is democracy; and in this I have always believed."

G. K. Chesterton, *Orthodoxy*, 1908.

IN THE

# Supreme Court of the United States

October Term, 1975

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No. 75-1064

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JACK B. KREMENS, Individually and as Hospital Director of Haverford State Hospital; FRANK S. BEAL, Individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; WILLIAM B. BEACH, JR., Individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,

Appellants

v.

KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND; Minors, Through Their Next Friend, Individually and on Behalf of All Others Similarly Situated,

Appellees

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On Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania

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## BRIEF FOR THE MICHIGAN ASSOCIATION OF EMOTIONALLY DISTURBED CHILDREN AS AMICUS CURIAE

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## STATEMENT OF PURPOSE AND PRIOR PROCEEDINGS

I. THE MICHIGAN ASSOCIATION FOR EMOTIONALLY DISTURBED CHILDREN IS AN ADVOCATE FOR MENTALLY ILL CHILDREN, AND TO THAT END FILES THIS BRIEF AMICUS CURIAE IN SUPPORT OF THE POSITION OF THE APPELLANT.

The Michigan Association for Emotionally Disturbed Children (MAEDC) is a non-profit, charitable organization comprising over two thousand parents, professionals and concerned citizens. Its single, unadulterated purpose is to promote the well-being of children suffering emotional and mental illness. To that end, MAEDC files this brief *amicus curiae* in support of the position of the Appellant.[1]

MAEDC was formed in 1957. At that time, there were few separate, public treatment facilities for mentally ill children in Michigan. Mentally ill children were usually hospitalized on adult wards. There were few community alternatives to hospitalization. There were no special education programs for mentally ill children. There were no community-based day treatment services for mentally ill children.

Since 1957, services for mentally ill children in Michigan have been significantly expanded and improved. Funding of public mental health services for children has been increased. Several public, inpatient facilities devoted exclusively to treating emotional disturbance in children have been established. Special education programs for emotionally disturbed children have become part of public school curricula. Community alternatives to hospitalization, such as day treatment and residential facilities, have been greatly augmented. Public awareness and personal awareness (by parents of emotionally disturbed children) that mental illness is a medically treatable sickness rather than a social stigma have been fostered.

Since 1957, Michigan's inpatient population of approximately six hundred mentally ill children has not grown

[1] MAEDC submits this brief *amicus curiae* with the written consent of all parties to the case. See Appendix, *infra*, at p. 1a.



despite an increase in Michigan's overall child population. The average period of hospitalization has been reduced from over two years in 1957 to less than one year in 1976.

MAEDC fought for and helped achieve each of these advancements.[2]

## II. IT IS THE BELIEF AND EXPERIENCE OF MAEDC THAT, IF SUSTAINED, THE DECISION OF THE LOWER COURT IN *BARTLEY* v *KREMENS* WOULD SERIOUSLY HARM MENTALLY ILL CHILDREN IN MICHIGAN.

In *Bartley* v *Kremens*, 402 F Supp 1039 (ED Pa 1975), a two-judge majority of the three-judge court found Pennsylvania's statutory and regulatory scheme for voluntary hospitalization of mentally ill children unconstitutional.[3] The majority held that hospitalizing a child for treatment of mental illness upon the application of his parents (and the concurrence of two physicians) violated the constitutional requirement of due process.

The *Bartley* court also prescribed an admission procedure containing the requisite elements of "due process": (1) An initial judicial hearing within seventy-two hours of hospitalization to determine whether there is probable cause to believe that hospitalization is necessary; (2) A full commitment judicial hearing within two weeks of hospitalization; (3) A finding by clear and convincing proof at the full commitment hearing that hospitalization is neces-

[2] See Affidavit of Samuel L. Davis in Appendix, *infra* at p. 2a.

[3] The *Bartley* decision applied to both mentally ill children and retarded children. MAEDC is not directly involved in protecting the interests of retarded children. Therefore, this brief will be limited to an analysis of the issues from the standpoint of mentally ill children.

sary;[4] (4) Appointment of counsel to represent the child at all significant stages of the hospitalization process; (5) Written notice to the child and his attorney stating the time and place of all hearings and the grounds for proposed hospitalization; (6) Presence of the child at all hearings, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the child's behalf.

Michigan's statutory scheme for the voluntary hospitalization of children is substantially the same as Pennsylvania's combined statutory and regulatory scheme. MSA 14.800 (415) *et seq*, MCLA 330.1415 *et seq*.[5] The Michigan Mental Health Code provides for voluntary hospitalization of a mentally ill child upon his parents' application and the hospital director's determination that the child needs inpatient treatment. A child thirteen years of age or older can object to hospitalization. Additionally, a suitable person can object to any child's hospitalization regardless of the child's age. The hospital must assist the child in submitting his objection to the court. An objection triggers appointment of counsel and an adversary judicial proceeding within seven days to determine the necessity of hospitalization.

[4] The court below did not order a "pre-commitment hearing" because that would discourage parents from making a difficult but necessary decision to hospitalize their child. *Bartley* v *Kremens*, *supra* at 1039. Instead, the court ordered *two* full-blown, adversarial hearings within two weeks of hospitalization. Is the latter any less discouraging than a hearing prior to admission? In either case, parents must "win" a court hearing on their child's insanity in order to secure sustained, inpatient treatment for their child.

[5] The relevant portions of Pennsylvania's statute and regulations are set forth in *Bartley* v *Kremens*, supra at 1041-43. The relevant portions of the Michigan Mental Health Code are set forth in the Appendix, *infra* at 124a.



MAEDC advocated the enactment of the objection provisions in the Michigan Mental Health Code. At the same time, MAEDC advocated the enactment of the voluntary admission provisions which respect the obligation and right of parents to provide for the needs of a mentally ill child without stigmatizing their child as insane in public court records and adversary judicial proceedings.

If sustained, the *Bartley* decision would eliminate voluntary admissions under the Michigan Mental Health Code. MAEDC supports the Appellant in the instant case because it is the belief and experience of MAEDC that such a result would seriously harm mentally ill children in Michigan.

## III. LITIGATION INVOLVING HOSPITALIZATION OF MENTALLY ILL CHILDREN IN MICHIGAN WHICH IS RELEVANT TO A REVIEW OF THE DECISION IN *BARTLEY* v *KREMENS*.

During the past two years, MAEDC has participated in two lawsuits challenging the constitutionality of Michigan's statutory scheme for voluntary admissions of mentally ill children.

*Clarice Jobes, et al* v *Michigan Department of Mental Health, et al*, Case No. 74-004-130 DC (Wayne Cty Cir Ct, MI, 1974) (hereinafter *Jobes* v *Michigan*), is a class action in state court on behalf of all children hospitalized in public mental health facilities pursuant to the voluntary admission provisions of the Michigan Mental Health Code.[6] Michigan Legal Services is counsel for the plaintiffs in

[6] Initially, *Jobes* attacked the voluntary admission provisions of the statutory forerunner to the Michigan Mental Health Code. The Code was enacted while the *Jobes* suit was pending. Voluntary admission under the former statute [MSA 14.809(1), MCLA 330.19a] were substantially the same as under the present Code, except the former statute did not provide for objections to hospitalization.

*Jobes*. The plaintiffs contend that the due process and equal protection provisions of the United States Constitution mandate that every sick child be accorded the full panoply of criminal due process protections as a prerequisite to hospitalization by his parents. MAEDC intervened in *Jobes* as a defendant because it did not believe that Michigan Legal Services truly spoke for the best interests of mentally ill children. In October of 1974, the court in *Jobes* granted a motion for partial summary judgment by MAEDC and the State defendants. The court found, *inter alia*, that:

> "[T]he judicial relief prayed by plaintiffs would, in virtually every case, result in a minor child acquiring a permanent public record of mental or emotional infirmity. Can one assume that few or no children would look askance at the possibility of such a record—a record which could interfere with the child's opportunity to work at a desirable job or to study in a desirable school or college?
>
> "Can we assume that few or no children would view with alarm the stigma which would possibly arise from a permanent, public record of mental or emotional infirmity? Many children might see the plaintiffs' victory not as a blessing, but as a curse. *One can readily imagine some children saying to the plaintiffs, 'If you want to help us, drop your lawsuit.'* " (Emphasis supplied.)[7]

Since the entry of partial summary judgment in favor of the defendants, the *Jobes* suit has been dormant.

In November of 1975, Michigan Legal Services combined with two sister agencies, Legal Services of Eastern Michigan and Washtenaw County Legal Aid Society, and filed a class action in federal court on behalf of all children

[7] The full Opinion of the Court in *Jobes* v *Michigan* is included in the Appendix, *infra* at p. 4a.



hospitalized in public mental health facilities pursuant to the voluntary admission provisions of the Michigan Mental Health Code. This lawsuit is captioned *Tom Wojciehowski, Next Friend of John Doe, Jr., a minor, on behalf of John Doe, Jr. and all others similarly situated* v *The Director of the Michigan Department of Mental Health, et al*, Case No. 75-72318 (ED Mich 1975) (hereinafter *Wojciehowski* v *Michigan*). The plaintiffs in *Wojciehowski* contend that the due process and equal protection provisions of the United States Constitution mandate that every sick child be accorded the full panoply of criminal due process protections as a prerequisite to hospitalization by his parents.

The posture of the *Wojciehowski* case illuminates a threshold, jurisdictional issue not addressed in *Bartley*.

> CAN A STRANGER TO A FAMILY STOP INPATIENT TREATMENT FOR AN EMOTIONALLY DISTURBED CHILD BY FILING SUIT AS "NEXT FRIEND" OF THE CHILD ABSENT A PRIOR SHOWING IN A STATE COURT OF COMPETENT JURISDICTION THAT THE PARENTS RESPONSIBLE FOR HOSPITALIZING THEIR CHILD ARE UNSUITABLE?

The *Bartley* decision presupposes federal jurisdiction notwithstanding the absence of a prior state court action divesting the parents of their right to custody and control of their child. That supposition, which radically alters traditional concepts of the parent-child relationship, is an important aspect of *Bartley* which MAEDC hopes this Court will consider in reviewing *Bartley*. Accordingly, MAEDC need apprise this Court of the relevant facts in *Wojciehowski* which frame the above-mentioned issue.[8]

[8] The Complaint and the Answer and Affirmative Defenses of the Intervenor/Defendant (the parents of John Doe, Jr.) in *Wojciehowski* v *Michigan* are set forth in the Appendix, *infra* at p. 29a.

The nominal plaintiff in *Wojciehowski,* John Doe, Jr., is eleven years old. He has been an inpatient at York Woods Center for Children for about two-and-a-half years. He was hospitalized pursuant to the voluntary admission provisions of the Michigan Mental Health Code.

John has a long history of severe mental and emotional disturbance. Since about age four, John has manifested: encephalopathy (brain damage); many of the features of an autistic child; borderline retarded intellectual potential and functioning; possible arrested hydrocephaly; psychotic-like behavior; borderline psychotic personality disorder; deep seething rage; an inability to distinguish fantasy from reality; latent schizophrenia; possible childhood schizophrenia; an obsessive preoccupation with death, blood and gore; bizarre and wildly fluctuating relationships with people in his life; compulsive, violent, assaultive behavior; enuresis and encopresis; severe anxiety and withdrawal; echolalia with bizarre and totally inappropriate verbal responses.

Mr. and Mrs. Doe love their son. They hospitalized John because they believed his problems necessitated the sustained, inpatient medical treatment available at York Woods. They reluctantly reached this decision after years of consultation with, and in accordance with the advice of, numerous psychiatrists, physicians, psychologists and other professional personnel trained in the diagnosis and treatment of mental illness.

Mr. and Mrs. Doe have closely supervised their son throughout his hospitalization at York Woods. They have visited their son on a regular, frequent basis and have taken their son from the hospital for family visits at least one day each week. At York Woods, John has made substantial



progress. Mr. and Mrs. Doe hope to remove their son from York Woods in the Summer or Fall of 1976 so that he may live at home while continuing his medical treatment on an outpatient basis.

Mr. Wojciehowski, the "next friend," is a student teacher who visited John periodically at York Woods through a "big brother" program. As "big brother" to John, Mr. Wojciehowski was fully apprised in writing of the procedure whereby any suitable person can object to a child's hospitalization.

In May of 1975, Mr. Wojciehowski distributed confidential and inaccurate information regarding John to unauthorized persons in violation of the Michigan Mental Health Code. *See* MSA 14.800(746), MCLA 330.1746. Accordingly, York Woods terminated Mr. Wojciehowski as a "big brother." In turn, Mr. Wojciehowski and his attorneys brought their lawsuit "on behalf of" John Doe, Jr. This was accomplished by the simple expedient of affixing John Doe, Jr's. name to their complaint.[9]

Mr. and Mrs. Doe did not authorize or consent to the

[9] Prior to filing their complaint, Mr. Wojciehowski and his attorneys unsuccessfully petitioned for the intervention of John Doe, Jr. in *Deborah White* v *The Michigan Department of Mental Health, et al,* Case No. 75-10022 (ED Mich 1975). *White* is yet another class action, by the same legal aid agencies as in *Jobes* and in *Wojciehowski,* challenging the constitutionality of voluntary admissions for children under the Michigan Mental Health Code. In denying the petition to intervene, the Federal District Court noted that embroiling John Doe, Jr. in a complex class action would be adverse to the child's best interests. The court reasoned that John Doe, Jr. was already a member of the putative class in *White.* Further, the court advised Mr. Wojciehowski and his attorneys that they could best serve the interests of John Doe, Jr. and obtain expeditious relief by filing a writ of *habeas corpus* or by filing an objection to hospitalization pursuant to Sec. 417 of the Code. This was in September of 1975. Mr. Wojciehowski and his attorneys ignored the court's advice and filed *Wojciehowski* v *Michigan* in November of 1975.

lawsuit. They did not even know about the lawsuit. They first heard about the lawsuit on a radio broadcast.

One of the attorneys claiming to represent John Doe, Jr. was quoted by a newspaper as saying "as far as we're concerned the parents have nothing to do with it."[10] Mr. and Mrs. Doe disagreed. They wanted their son to continue receiving beneficial medical treatment at York Woods. They did not believe Mr. Wojciehowski and his attorneys shared their parental love and concern for John's best interests. They did not want Mr. Wojciehowski and his attorneys making critical parental and medical decisions regarding treatment of their son's sickness.

The Does are a working class family. Mr. and Mrs. Doe cannot afford private counsel for complex litigation and do not qualify for assistance from the legal aid agencies claiming to represent their son. MAEDC provided Mr. and Mrs. Doe with counsel so that they could intervene as defendants in *Wojciehowski* and protect the nominal plaintiff, their son.

The complaint in *Wojciehowski*, which used John Doe, Jr's actual name, generated a great deal of publicity. The court struck the child's actual name from the pleadings, and substituted a pseudonym, in order to protect the child and his parents from further public stigmatization and embarrassment. The court granted a motion to appoint Mr. Wojciehowski "next friend" of John Doe, Jr., the nominal plaintiff.

The turmoil of the lawsuit, the creation of an *artificial* adversary relationship between John and his parents, and unsuccessful attempts by Mr. Wojciehowski's attorneys to

[10] "Parents Battle Son's Lawsuit," Detroit Free Press, December 14, 1975.



elicit the child's approval for the lawsuit, have intensified John's manifestations of mental illness and retarded his progress.

Presently, the court in *Wojciehowski* is deliberating whether to stay further proceedings pending the decision of the United States Supreme Court in *Bartley* v *Kremens*.

## SUMMARY OF ARGUMENT

The decision in *Bartley* v *Kremens*, 402 F Supp 1039 (1975), invites strangers to the family, next friends and court-appointed attorneys, to usurp custody and control of parents over their sick child. Under *Bartley*, "children's spokesmen," who are unrestrained by bonds of love and affection, could meddle in the familial relationship without any due process for parents. The domestic relation of child *and* parents would become child *against* parents. Federal courts are without primary jurisdiction to radically redefine the parent-child relationship which is within the special competence of state courts.

*Bartley* inverts the constitutionally recognized principle that parents have a duty and right to secure appropriate medical treatment for their sick child. To protect emotionally disturbed children *against* their parents, the court below prescribed a full-blown, adversary proceeding as a condition for hospitalization. Such a mandatory hearing, together with the other "due process" procedures ordered below, would be a forbidding and often insurmountable obstacle to the receipt of necessary medical treatment. If sustained, the predictable effect of the *Bartley* decision will be to deny emotionally disturbed children critically needed inpatient services.

The due process analysis of the *Bartley* court is based

on a misconception of both the sick child's "private interest" and of the "governmental function" involved when parents avail themselves of state resources to secure necessary treatment for an emotionally disturbed child. The "private interest" of a sick child is nurturing parental oversight, not freedom from hospitalization. The "governmental function" of the state is merely to assist parents in fulfilling their duty and right to secure medical treatment for their child. The "due process" procedures prescribed in *Bartley*, which pit parent against child, are unwarranted and without precedent in our democracy.

## ARGUMENT

### I. PARENTS HAVE A CONSTITUTIONALLY RECOGNIZED DUTY AND RIGHT TO SECURE APPROPRIATE MEDICAL TREATMENT FOR A SICK CHILD.

Parental accountability is the lynchpin of social organization in a democracy. In *Wisconsin* v *Yoder*, 406 US 205, 232, 32 L Ed 2d 15, 92 S Ct 1526 (1972), Chief Justice Burger stated for the majority:

> "The history and culture of Western civilization reflects a strong tradition of parental concern for the nurture and upbringing of their children. The primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition."

In *Stanley* v *Illinois*, 405 US 645, 651, 31 L Ed 661, 92 S Ct 1208 (1972), Justice White stated for the majority:

> "The private interest here, that of a man in the children he has raised, undeniably warrants deference and, absent a powerful countervailing interest, protection. It is plain that the interests of a parent in the companionship, care, custody and management of his or her children, 'come[s] to this court



> with a momentum for respect . . .,' *Kovacs* v *Cooper*, 336 US 77, 95, 93 L Ed 513 69 S Ct 448 (1949)."

In *Ginsberg* v *New York*, 390 US 629, 639, 20 L Ed 2d 195, 88 S Ct 1274 (1968), Justice Brennan stated for the majority:

> "[C]onstitutional interpretation has consistently recognized that the parent's claim to authority in their own household to direct the rearing of their children is basic in the structure of our society."

In *Pierce* v *Society of Sisters*, 268 US 510, 535, 69 L Ed 1070, 45 S Ct 571 (1925), Justice McReynolds stated for the court:

> "The child is not the mere creature of the state; those who nurture him and direct his destiny have the right coupled with the high duty to recognize and prepare him for additional obligations."

Voluntary admissions under Pennsylvania and Michigan law are bottomed on the principle of parental accountability. A child is helpless during his formative years. Parents are the presumed *protectors* of their child. Parents, not the state, are the child's primary guardian. Voluntary admissions permit conscientious parents to discharge their responsibility to care for their child.

In a democracy, the state intervenes only when the familial relationship breaks down. *See* Locke, *Treatise of Civil Government*, 3450 (Sherman Edition 1937). Responsibility could have been distributed differently—totalitarian societies have chosen to undermine the family and substitute the state for the parent—but we have rejected that choice. *Cf. Meyer* v *Nebraska*, 262 US 390, 401-02, 67 L Ed 1042, 43 S Ct 625 (1929).

The law has fostered parental accountability to insure the nurturing assistance children need during their formative years. Parents, not the state, must support, maintain

and care for their offspring. *See, e.g.,* MSA 25.244(3), MCLA 722.3; *Dunbar* v *Dunbar,* 190 US 340, 47 L Ed 1084, 23 S Ct 757 (1902); *Babcock* v *Fisk,* 327 Mich 72, 41 NW 2d 479 (1950). Parental responsibility extends to the child's medical needs. *See, e.g., Herbstman* v *Shifton,* 363 Mich 64, 108 NW 2d 869 (1961); 59 Am Jur 2d, Parent and Child, §§15, 59. Parental responsibility includes engendering socially acceptable conduct in their child. Parents are vicariously liable for their child's misbehavior. *See, e.g.,* MSA 27A.2913, MCLA 600.2913; MSA 13.1064(3), MCLA 318.253; *Dortman* v *Lester,* 380 Mich 74, 155 NW 2d 827 (1968); *McKinney* v *Caball,* 40 Mich App 389, 198 NW 2d 713 (1972); *Prosser on Torts* (1964), Domestic Relations, §117. In fact, criminal sanctions have been prescribed to foster parental accountability. *See, e.g.,* MSA 25.237, MCLA 722.561; MSA 25.238, MCLA 722.562; MSA 28.331, MCLA 750.136; MSA 28.358, MCLA 750.161.

The state institutes programs to assist parents, but no arm of the state has ever contrived to eliminate parental accountability. *Cf. Meyer* v *Nebraska, supra* at 402.

The *Bartley* majority acknowledged, in passing, the "presumption" that parents act in the best interest of their child. *Bartley* v *Kremens, supra* at 1047. Then, the court turned the presumption upside down and fashioned an elaborate "due process" system to "safeguard" every child *against* his parents.

Parental accountability for the care and custody of children is a "compelling public interest." *Yakus* v *United States,* 321 US 414, 88 L Ed 834, 64 S Ct 190 (1944). It is "essential,"[11] "cardinal,"[12] a "basic civil right,"[13] and

[11] *Meyer* v *Nebraska,* supra at 399.
[12] *Prince* v *Massachusetts,* 321 US 158, 166, 88 L Ed 645, 64 S Ct 438 (1944).
[13] *Skinner* v *Oklahoma,* 316 US 535, 541, 86 L Ed 1655, 62 S Ct 1110 (1942).



"far more precious than property rights."[14] *Bartley* would replace parental concern with parental *malice* toward emotionally disturbed children. Such a sweeping conclusion should be supported by equally persuasive evidence that parents of emotionally disturbed children are bad parents. The *Bartley* majority made no such findings.[15]

The United States Supreme Court has enforced parents' duty and right to supervise their childs' education. *Meyer* v *Nebraska, supra; Pierce* v *Society of Sisters, supra.* Why should that principle be inverted when treatment for mentally ill children is involved? Indeed, why should *mentally* ill children be denied the nurturing parental supervision allowed physically ill children? If parents can consent to radiation therapy to treat cancer, why can't parents consent to psychotherapy to treat suicidal depression? If parents are not accountable for the *medical* needs of an emotionally disturbed child, are they still accountable for the *non-medical* needs of such child? If parents cannot *admit* their emotionally disturbed child to a hospital, can parents *withdraw* their child from a hospital?

The *Bartley* majority points to "the stigma associated with civil commitment" as a basis for prescribing "due process" strictures which *guarantee* such stigma. *Bartley* v *Kremens, supra* at 1046. Voluntary admissions permit conscientious parents to secure appropriate, inpatient treat-

[14] *May* v *Anderson,* 345 US 528, 533, 97 L Ed 1221, 73 S Ct. 840 (1953).

[15] Indeed, as Judge Broderick noted in his Dissenting Opinion in Bartley, "The record in this case demonstrates that most parents act in the best interests of their child when making the decision to voluntarily submit their child to institutional treatment." *Id,* 1057. See also expert Affidavit of Dr. Ralph D. Rabinovitch included in Appendix, *infra,* at p. 73a.

ment for their child without stigmatizing their child as insane in public court records and adversary court proceedings. Under *Bartley,* voluntary admissions would be eliminated. Every child hospitalized for emotional disturbance would have a public record and judicial determination of his mental infirmity. *Jobes* v *Michigan, supra; Bartley* v *Kremens* (Dissent), *supra,* at 1057.

The *Bartley* majority concluded that parents, as presumptive adversaries of their child, cannot "waive" their child's "right" to "freedom from hospitalization." Instead, every child must have a court-appointed lawyer who *can* waive the child's right to freedom from hospitalization.[16]

How will the lawyer, a stranger to the child, discharge his duty? If he is indifferent, he will rubber stamp the judgment of the parents and the hospital. If he is sensitive to his ethical and legal responsibilities (or greedy for taxpayer subsidization of his legal practice), he will vigorously assert the child's "right" to "freedom from hospitalization" (regardless of the child's need for hospitalization) in full-blown, adversary proceedings, whenever the slightest doubt clouds his uninformed judgment. The child will be the maleficiary of the lawyer's lack of parental and medical knowledge and qualifications, since the child will have an "opportunity" to be traumatized and stigmatized by court proceedings. Finally, cruelly, the parents will be required to prove their child is insane.[17]

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[16] See the court's Final Order in *Bartley* v *Kremens* in Appendix to Jurisdictional Statement filed with the United States Supreme Court by the Pennsylvania Department of Justice at p. 102a.

[17] The *Bartley* court did not provide court-appointed counsel for the parents, who may themselves be indigent. If the parents prevail "against" their child, will the state pay their costs and attorney fees?



Guaranteed "public stigmatization" would be just one of the evil effects of the *Bartley* decision. Its harshest effect would be to deny emotionally disturbed children and their families desperately needed treatment and services.

The affidavit of expert Dr. Ralph Rabinovitch, which appears in the Appendix, describes real cases which illustrate the predictable effect of mandatory, adversary commitment proceedings.

George was an eleven-year-old with severe school phobia. He had difficulty leaving his house even for brief periods of time. He sat at home day and night. His problems dated back to his early school days. Almost two years of psychotherapy in the community had not helped. Both the school and the community clinic strongly recommended inpatient treatment for George, but it took many months and much supportive assistance before the parents were able to confront George's need for hospitalization and accept that recommendation. In the hospital, George responded rapidly. He was able to return home and to public school in three months and continues to do well. Had George and his parents been required to undergo the ordeal of an adversary court hearing as a condition of hospitalization, George would probably still be at home, by himself day and night.

Joyce was an elective mute. This emotional problem was recognized when Joyce was seven years old. Injatient care was recommended, but for almost five years Joyce's parents were so troubled by fear and anxiety that they could not bring themselves to hospitalize Joyce. For almost five years, Joyce remained at home and mute. Her social adjustment deteriorated. She became withdrawn and depressed. Finally, Joyce was hospitalized by her parents. She responded to treatment. In five months, she returned

to her home and to public school where she is adjusting well, talking comfortably and enjoying life. Had Joyce and her parents been required to undergo the ordeal of an adversary judicial hearing as a condition of hospitalization, Joyce would probably still be an elective mute, withdrawn and depressed.

Would George and Joyce have benefited from their "right" to "due process" and "freedom from hospitalization?"

George and Joyce are typical examples of the clinical reality that many loving parents have great emotional difficulty in accepting and acting upon their child's need for inpatient treatment of emotional disturbance. In some instances, concerned parents plagued with fear and anxiety wait too long. Then, the ultimate tragedy occurs—suicide or homicide.

Poor families, who are most dependent on public assistance for mental health problems, are also most vulnerable to the fears and anxieties which inhibit all parents from seeking and accepting necessary hospitalization for treatment of emotional disturbance in children.

By replacing voluntary admissions with adversary commitment proceedings, *Bartley* would manufacture a forbidding, often insurmountable, obstacle to receipt of critical medical services. Many loving parents, particularly among poor families, would be unwilling to subject their emotionally disturbed child and themselves to the trauma and stigma of adversary judicial commitment proceedings.[18]

[18] The amplified distrust of poor families toward governmental functions, such as public mental health facilities and judicial proceedings, is a social and clinical fact which the judiciary itself has often recognized. *See, e.g., Reist* v *Bay Circuit Judge*, 396 Mich 326, 345, 241 NW 2d 55 (1976) where the Michigan Supreme Court stated:

"'The indigent are frequently the least able to cope with government in its official functions. See Paulsen, *Juvenile Courts, Family Courts, and the Poor Man*, 54 Cal L Rev 694 (1966). The case at bar was routine for the welfare workers and other juvenile court staff. For the indigent mother, however, the entire proceedings were incomprehensible.' *State* v *Jamison*, 251 Or 114, 116-117, 444 P 2d 15, 17 (1968)."



Many sick children, particularly among poor families, would be denied desperately needed inpatient treatment. "Ultimate tradegies" would proliferate.[19]

Voluntary admissions embrace the principle of parental accountability and respect the confidentiality of the child and his family. *Bartley* discards that principle and turns the relationship of parent and child topsy-turvy. It is preposterous to assume that parents, doctors and social workers are engaged in a malevolent conspiracy against children who suffer mental illness. Yet that is precisely what the majority in *Bartley* must have assumed when it ruled that *every* emotionally disturbed child must have a court-appointed lawyer and an adversary hearing to protect the child against his parents, doctors and social workers. That assumption is completely unfounded and at variance with the very social and legal traditions which gave content to the concept of due process.

An "overdose of due process"[20] should not be used to destroy the familial relationship which gives meaning to "due process" in a democracy. All children, including the mentally ill, can best be protected by those persons uniquely suited to love them and to understand their needs—their parents.

[19] Included in the Appendix, *infra* at p. 73a, is the expert Affidavit of Dr. Ralph D. Rabinovitch concerning the reactions of families to hospitalization for mentally ill children, George and Joyce, and the predictable effect of mandatory, adversary commitment hearings.

[20] See Dissenting Opinion of Judge Broderick in *Bartley, supra* at 1054.

## II. THE HOSPITALIZATION OF AN EMOTIONALLY DISTURBED CHILD BY HIS PARENTS DOES NOT CALL FOR THE OVERDOSE OF PROCEDURAL DUE PROCESS PRESCRIBED BY THE COURT BELOW IN *BARTLEY* v *KREMENS*.

The *Bartley* majority held that before an emotionally disturbed child can receive sustained, inpatient treatment, there must be a complete adversarial commitment proceeding between the sick child and his parents. To so conclude, the court reasoned that inpatient medical treatment raised a due process issue because hospitalization deprives a child of liberty by the state. That analysis may be valid when the *state* hospitalizes a child; but it is singularly inappropriate when *parents* fulfill their familial duty by hospitalizing their sick child.[21]

In *Cafeteria Workers* v *McElroy*, 367 US 886, 895, 6 L Ed 2d 1230, 81 S Ct 1743 (1961), the United States Supreme Court explained that the proper amount of due process depends upon the "nature" of the "private interest affected" and of the "governmental function involved."

> "The very nature of due process negates any concept of inflexible procedures universally applicable to every imaginable situation . . . what procedures due process may require under any given set of circumstances must begin with a determination of the precise nature of the government function involved as well as of the private interest that has been affected by governmental action."

The due process analysis of the *Bartley* majority is based on a misconception of both "the private interest affected"

[21] In effect, *Bartley* would extend the status of emancipation at birth. Children of the Victorian era were "free" at birth. They were given the same right as adults to wander the streets, live in alms houses, work in textile mills, and work in mines. "The New Child: No Kidding," Newsweek, March 4, 1974.



and "the governmental function involved" when parents secure inpatient treatment for their mentally ill child.

### A. When Parents Secure Inpatient Treatment For Their Emotionally Disturbed Child, The "Private Interest" Of The Child Lies Within The Framework Of The Parent-Child Relationship.

The *Bartley* majority ignored the fact that the child's interests cannot be determined apart from his parents unless they are neglectful. It substituted an untested fiction for cherished social and legal principles by assuming that lawyers and judges, strangers to the family, are better qualified than parents to protect the best interests of a sick child.

Who would really be heard in the burlesque of "due process" prescribed in *Bartley? Not the child.* The child, burdened with the disabilities of age and illness, is effectively mute whether represented by his parents or by strangers. The *Bartley* decision invites meddling in the parent-child relationship by strangers who, unrestrained by the bonds of family, may themselves be invidiously motivated. *Wojciehowski* v *Michigan, supra,* was started by a "big brother" in retaliation for his discharge. If sustained, *Bartley* would expose the family to forays by strangers whose motives are untested and whose dedication to "their client" arises at best out of ideological conviction rather than personal love and affection.

As already shown, parental custody and care is a constitutionally recognized principle at the heart of our legal and social traditions. *Bartley* discards that principle and pits parent against child.

*Bartley's* juxtaposition of child against parent is contrary to this Court's teachings in *In re Gault*, 387 US 1, 18

L Ed 2d 527, 87 S Ct 1428 (1967). *Gault*, misunderstood by the majority below, is the Supreme Court's most complete statement on procedural due process for juveniles. That statement consistently treats the interest and rights of parent and child *in tandem* rather than in discord.

In *Gault*, the state had sentenced a fifteen-year-old boy to three year's detention in a home for juvenile delinquents because the boy allegedly had violated an obscure misdemeanor provision of the Arizona Criminal Code. The Supreme Court noted that a minor "cannot be judged by the more exacting standards of maturity" because childhood is a "period of great instability." *Id*, 45. Viewing the state action as an abridgement of "the youth's freedom and his *parents' right to custody*" (*Id*, 34), the Court prescribed due process protections *for a child and his parents* when the child is charged with a crime.

The "*child and his parents*" have a right to written notice of specific charges. *Id*, 35. The "*child and his parents*" have a right to counsel. *Id*, 41. The right to counsel, the Court suggests, might be waived by the parents. *Id*, 42. The child has a privilege against self-incrimination which might be waived, "depending upon the age of the child and the *presence and competence of parents.*" *Id*, 55. Absent waiver of the privilege and a valid confession, the child has a right of confrontation and cross-examination. *Id*, 56-57.

Thus, in the quasi-criminal context of juvenile delinquency, this Court's "judicious balance"[22] *embraces* the fundamental principles of parental custody and consent. In the medical context of treatment for emotionally disturbed children, there is no justification for discarding pa-

[22] See *McKeiver* v *Pennsylvania*, 403 US 528, 545, 29 L Ed 2d 647, 91 S Ct 1976 (1973).



rental accountability for presumptive parental malice. Mentally ill children are not criminals. Mental health hospitals are not jails. Parents are not prosecutors. The child's "private interest" is his fundamental right to nuturing parental oversight.

### B. When Parents Secure Inpatient Treatment For Their Emotionally Disturbed Child, The "Governmental Function Involved" Is To Assist Parents In Fulfilling Their Parental Duty.

The *Bartley* majority treats an emotionally disturbed child's hospitalization *by his parents* as a deprivation of the child's liberty *by the state*. In so doing, the court below erred.

The governmental function in voluntary admissions is *not* an impairment of individual rights by the state. Parents, not the state, are primarily responsible for hospitalizing (or not hospitalizing) their child. Parents, not the state, are primarily responsible for continuing (or stopping) hospitalization for their child.

The state's primary function is to provide mental health services and facilities which permit conscientious parents to fulfill their familial responsibility to their sick child. The state licenses and inspects hospitals; it provides doctors, psychologists, social workers, nurses and attendants. It does all this so that parents can secure necessary medical treatment for their child.

The *Bartley* majority regarded parents as presumptively malevolent and totally excluded parents from "due process." It fashioned "due process" hospitalization procedures between the sick child and the state without even mentioning the parents. Treating parents as irrelevant at

best, the court below manufactured an elaborate child-state admission process which *would make* parents irrelevant to, or worse yet, prosecutors of their sick child.

*Bartley's* dark vision of the child-state equation is not reality in our democracy. Parents are neither presumptively malevolent nor irrelevant. Voluntary admissions under Pennsylvania and Michigan respect the primary and ultimate responsibility of parents to make critical decisions regarding treatment for their sick children. The state merely assists the parents.

The United States Supreme Court has found procedures like those prescribed in *Bartley* necessary only in situations where the state, *in fact, directly* impairs individual rights. *See, e.g., Gagnon* v *Scarpelli*, 411 US 788, 36 L Ed 646, 93 S Ct 1956 (1973) where the state directly revoked an individual's probation; *Morrissey* v *Brewer*, 408 US 471, 33 L Ed 484, 92 S Ct 2593 (1972) where the state directly revoked an individual's parole; *Goldberg* v *Kelly*, 397 US 254, 25 L Ed 287, 90 S Ct 1011 (1970) where the state directly terminated an individual's welfare benefits; *In re Gault, supra*, at 34, where the state directly impaired a "youth's freedom and his parents' right to custody."

No judicial (or legislative) body in this land has ever successfully prescribed such "due process safeguards" against *parents* who are directly discharging their responsibility to their sick child.



## III. A FEDERAL COURT IS WITHOUT JURISDICTION TO HEAR AND DECIDE MATTERS RELATING TO CUSTODY.

*Wojciehowski* v *Michigan, supra*, explictly frames a threshold, jurisdictional issue which is implicit in *Bartley* v *Kremens*. A stranger to the family attacks the hospitalization of a sick child on "constitutional grounds" behind the backs of the parents and against their wishes. A federal district court, without any hearing to determine the question of custody, appoints the stranger "next friend" to the child so that his (i.e. the stranger's) lawsuit can proceed. Without *any process* (due or otherwise), the parents are divested of significant control over their sick child. This Alice In Wonderland procedure is employed to vindicate a "due process" notion from which parental duties and rights are excluded.[23]

Federal courts are not family courts. Our federal system does not ask federal courts to hear cases concerning marriage, death, custody, dependency or neglect. This court has emphasized that fact in *Ex parte Burrus*, 136 US 586, 594, 34 L Ed 500, 105 S Ct 850 (1890):

> "The whole subject of the domestic relations of the husband and wife, parent and child, belongs to the states and not to the laws of the United States. As to the rights to control and possession of [children], . . . it is one in regard to which neither the Congress of the United States nor any authority of the United States has any special jurisdiction."

[23] *Cf. Reist* v *Bay Circuit Judge* 396 Mich 326, 341-42, 241 NW 2d 55 (1976):

> "The interest of parent and child in their mutual support and society are of basic importance in our society and their relationship occupies a basic position in this society's hierarchy of values. Clearly any legal adjustment of their natural rights and obligations affects a fundamental human relationship. The rights at stake are 'protected' and encompassed within the meaning of the term 'liberty' as used in the Due Process Clause.

By what right were John Doe, Jr. in *Wojciehowski* and the child-plaintiffs in *Bartley* drafted from the custody of their parents to serve as "clients" for strangers? This question is at the core of the *Bartley* case.

If parents cannot hospitalize their child in reliance on medical advice, can parents send their child to summer camp, to boarding school, to church? Can any child "threatened" by parental action now tell his parents to talk to his lawyer?

*Magaziner* v *Montemuro,* 468 F 2d 782 (3rd Cir 1972) focused on many of the issues raised by *Bartley*—"children's rights," procedural due process, and federal jurisdiction over domestic relations. The plaintiffs were children. A state court judge had refused to allow them to be represented by counsel in a custody proceeding between their parents. The children filed suit in federal court under 42 USC §§1981 and 1983. They claimed that the state court judge had violated their constitutional right as "mature children" to representation in a custody proceeding. The federal district court dismissed the case. The Third Circuit noted that the plaintiffs had not used available state remedies such as *habeas corpus* and affirmed. The court based its decision, *inter alia,* on the doctrines of abstention [*Railroad Commission of Texas* v *Pullman Co,* 312 US 496, 85 L Ed 971, 61 S Ct 643 (1941)] and state jurisdiction over domestic relations [*Ex parte Burrus, supra*], reasoning that:

> "At the very least, if the status of 'mature children' confers rights and privileges not possessed by ordinary minors under Pennsylvania law, determination of this issue is a subject for adjudication by the state's judiciary and not for initial determination by the federal courts." *Id,* 786.[24]



The decision in *Bartley* and the proceedings in *Wojciehowski* encourage a new type of kidnapping. Instead of abduction for base purposes (ransom), children could be abducted for "lofty" purposes (to test the constitutionality of the law). If there is a right for custody in the United States, that right exists regardless of the purpose of the stranger to the family. Since the right for custody *does* exist, it can only be disturbed in a proper proceeding in a state court of competent jurisdiction. The federal courts are not within that definition.

## CONCLUSION

For the foregoing reasons the judgment of the court below should be reversed.

Respectfully submitted,
MILLER, KLIMIST, COHEN,
MARTENS & SUGERMAN, P.C.
BY: Bruce A. Miller
BY: Samuel C. McKnight
Attorneys for Michigan Association
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Detroit, Michigan 48226
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[24] See also *Boone* v *Wyman,* 295 F Supp 1143 (SD NY 1969), where a putative father filed a class action in federal court alleging a denial of due process under New York law which allowed a child born out of wedlock to be temporarily committed to a state foster care hospital by the mother. The district court recognized that a parent of a child cannot be deprived of custody without due process. The court stated that to grant the relief requested would be to embroil a federal court in a domestic "tug of war," and cited *Burris* for authority that such matters fall within the exclusive jurisdiction of state courts.

Mental Patient Civil Liberties Project

May 3, 1976

Barry Roth, Esquire
Office of Legal Counsel
Department of Public Welfare
Harrisburg, Pa. 17120

Re: *Kremens* v. *Bartley*

Dear Barry,

Pursuant to our telephone conversation today and your letter of April 29, 1976, I am pleased to consent to the filing of amicus curiae briefs in the Supreme Court of the United States by the following organizations:

American Psychiatric Association
Michigan Association for Emotionally Disturbed Children

The Melmark Home, Inc.; Deveraux Foundation; Woods School

You are authorized to convey this consent to these parties and the Court; since the American Psychiatric Association previously requested my consent, I will also be writing directly to it.

Matters relating to your other requested amicus, and to ours are dealt with in another letter I am sending you this date.

Sincerely,
/s/ David Ferleger
Attorney
cc: N. Watkins

MICHIGAN ASSOCIATION FOR
EMOTIONALLY DISTURBED CHILDREN

668 PALLISTER AVENUE • DETROIT, MICHIGAN 48202 • 313/TRINITY 3-3660

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EXECUTIVE DIRECTOR
Samuel L. Davis

AFFIDAVIT

I, Samuel L. Davis, after first being duly sworn, upon my oath affirm and state that:

I am the Executive Director of the Michigan Association for Emotionally Disturbed Children (MAEDC). I have held this position since 1960.

MAEDC is a Michigan non-profit corporation incorporated under Act No. 327 of the Public Acts of 1931, as amended. It has a membership of approximately 2000 and local chapters throughout the state of Michigan. It is financed in part through United Fund contributions and by dues and private donations. Its purposes, in part, set forth in its Articles of Incorporation are:

"To promote the welfare of emotionally disturbed children; to promote better understanding of their problems; to provide an opportunity for parents of such children to share their experiences and to support each other in meeting their problems; to encourage, subject to restrictions hereinafter set forth, the extension of present facilities and the provision of new ones, public and private, for the treatment and education of emotionally disturbed children, and for the training of psychiatrists, psychologists, nurses, teachers, social workers, and other professional personnel required for such treatment and education; to establish and maintain such facilities; to inform parents and others of the existence and facilities of clinics, schools, hospitals and institutions which provide treatment and education for emotionally disturbed children, to encourage and support research into the causes and treatment of emotional disturbance in children."



## AFFIDAVIT

The facts contained in Part I of the Statement of Purpose concerning MAEDC and the post-1957 developments in treatment and services for mentally ill children in Michigan are true.

/s/ SAMUEL L. DAVIS

Subscribed and sworn to before
me this 7th day of June, 1976.

/s/ CELIA T. BUCHINSKI,
Notary Public
Wayne County, Michigan
My commission expires October 8, 1978

STATE OF MICHIGAN
IN THE CIRCUIT COURT
FOR THE COUNTY OF WAYNE

CLARICE JOBES, on behalf of JANE DOE; a child called X, by her next friend and mother Ms. X, and other children similarly situated who are inpatients in the custody of the State Department of Mental Health; and members of the MEDICAL COMMITTEE FOR HUMAN RIGHTS, Plaintiffs,

v

MICHIGAN DEPARTMENT OF MENTAL HEALTH; E. G. YUDASHKIN, Director, State Department of Mental Health in his official capacity as well as his successors, agents, assignees, and employees in their official capacity; also the Director or Acting Director of LAFAYETTE CLINIC; CLYDE SIMSON, Director, Children's Psychiatric Unit, Lafayette Clinic; L. R. PIGGOTT, D. F. CALDWELL, and D. OBERLEAS, in their official capacity, as well as their agents, assignees, employees and successors at Lafayette Clinic, in their official capacities, Defendants,

and

MICHIGAN ASSOCIATION FOR EMOTIONALLY DISTURBED CHILDREN, and JOHN DOE and MARY DOE, parents of an emotionally disturbed child in a state mental health facility; and the COUNTY OF WAYNE, Intervening Defendants.

JUDGE VICTOR J. BAUM
(No. P-10556)

CIVIL ACTION
No.
74-004130-DC



## OPINION

### I - PLAINTIFFS' CLAIMS

The plaintiffs make four distinct claims. First, they contend that the constitutional rights of children to due process and equal protection of the law are violated when they are admitted to state mental hospitals, on a "voluntary" basis, with the informed consent of their parents, but without their own informed consent and without a hearing and approval by a court.[1]

Second, the plaintiffs contend that children are being unlawfully subjected to experimentation and research in state mental hospitals which take place without the informed consent of the children, without benefit to the patient, and without judicial approval.

Third, the plaintiffs claim that the Michigan Mental Health Department and certain hospitals operating under its auspices are unlawfully withholding, from public inspection, records and documents related to research and experimentation on children who are patients at such hospitals.

Respecting these three claims concerning children, the plaintiffs say that this is a class suit in which the named plaintiffs[2] assert the rights of other children who are similarly situated, as well as their own.

Fourth, one group of plaintiffs sue as taxpayers to bar expenditures of public funds which result from allegedly unlawful hospitalization of children and unlawful research and experimentation on them in public mental hospitals.

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[1] See paragraphs 14, 20, 25, and 28 of the plaintiffs' amended "petition/complaint."

[2] The phrase "named plaintiffs" includes those who are described by pseudonyms to protect their anonymity.

II - DESCRIPTION OF PARTIES

Plaintiff, CLARICE JOBES, was appointed by the Juvenile Court of Wayne County to be the attorney for plaintiff, JANE DOE, a seven-year-old ward of the Juvenile Court, who was, for a time, a patient at Lafayette Clinic, a state mental hospital. There, it is alleged that staff physicians sought to subject Jane Doe to medical experiments without her informed consent, without the informed consent of the Juvenile Court, and without a judicial determination, after a hearing, that the benefit to the patient from such experimentation would outweigh the attendant risks and burdens.

Plaintiff, X, is allegedly a nine-year-old child who was a patient, for a time, at Lafayette Clinic, admitted with the consent of her mother, the plaintiff, Ms. X. Allegedly, the consent given by Ms. X for child X's admission was coerced and was in other respects not an informed consent. It is alleged that child X was admitted to Lafayette Clinic without her own informed consent and without court approval.

Also, plaintiffs allege that physicians at Lafayette Clinic sought to subject child X to medical experiments without informed consent from the child and without a judicial determination, after a hearing, that the benefit to child X from the experiment would outweigh the attendant risks and burdens.

The taxpayer-plaintiffs and their theory have already been described.

The original defendants are the Michigan Department of Mental Health, its director, the director of Lafayette Clinic, and certain officials employed by Lafayette Clinic. Lafayette Clinic is a state mental health facility located in the City of Detroit.



Two defendants have intervened: The Michigan Association for Emotionally Disturbed Children and the County of Wayne. The County claims to have a multi-faceted interest in this litigation. It has a statutory obligation to provide for the care of mentally ill persons. It operates the Wayne County General Hospital, which provides inpatient and outpatient psychiatric care. The County has a statutory obligation to fund operations of the Probate Court, the court which would presumably conduct the hearings which would be required in the event the plaintiffs prevail.

The Michigan Association for Emotionally Disturbed Children is a non-profit corporation organized for the purpose of promoting the well-being of emotionally disturbed children and their parents. The Association seeks to have the court validate the practice of "voluntarily" admitting children to state mental hospitals upon the informed consent of parents, with the hospitals' concurrence, but without either the informed consent of the child or a judicial hearing. The Association opposes any decision by this court which would require a judicial or quasi-judicial finding of mental illness as a condition for such admissions.

III - THE PROCEEDINGS

Motions for summary or partial summary judgment have been filed by the plaintiffs, the defendant, Michigan Association for Emotionally Disturbed Children, and the defendant, Michigan Department of Mental Health.

The principal grounds for a full summary judgment of dismissal urged by the Association in its motion, briefs, and oral argument and which will be dealt with in this opinion are that,

1. The plaintiffs' lawsuit is not a proper vehicle for a class action and to treat it as such would de-

prive non-appearing members within the putative class of due process of law.

2. Plaintiffs have failed to state a claim upon which relief can be granted.

3. There is no actual controversy for which a declaratory judgment may be granted.

The defendant, Michigan Department of Mental Health, seeks a partial summary judgment dismissing plaintiffs' claims concerning the admission of children to state mental hospitals on the grounds that with the guaranties of individual rights in the newly enacted Mental Health Code,[3] hospitalization of children in public mental health facilities without their own informed consent, but with the informed consent of their parents, is lawful in all respects, despite absence of statutory provisions for a judicial hearing in advance of hospitalization.

The plaintiffs seek a partial summary judgment respecting their hospital admissions and research and experiment claims on the following grounds:

"1. That there are no disputed issues of fact concerning the admission of children to public mental hospitals and that as a matter of law, regardless of the parents' informed consent to such hospitalization, the constitutional rights of children are violated[4] by their admission or confinement in a state mental hospital without their informed consent and without a judicial hearing.

[3] MCLA 330.19a, et seq.; MSA 14.809(1), et seq., particularly its provisions for notifying children of their rights and affording them a court hearing soon after their admission with right to counsel and jury trial.

[4] — Including the right to due process of law, the right to equal protection of the laws, and the right to be free of cruel and unusual punishment —



"2. That the use of children in mental hospitals for experimentation or research without their informed consent and without judicial approval, following a hearing, violates like constitutional rights of the children."

## IV - CLASS SUIT ISSUE

Is the plaintiffs' complaint a proper vehicle for a class suit?

The complaint respecting hospital admissions, research, and access to hospital records, cannot be treated as a class suit for children in general. The named plaintiffs do not fairly insure the adequate representation of all of the members of the class as required by General Court Rule 208 because they are not members of the class whom they purport to represent.

For a class suit, General Court Rule 208 requires that the named plaintiffs will fairly insure the adequate representation of the members of the class. "This means, first of all, that the representatives must be actual members of the class." Honigman and Hawkins, *Michigan Court Rules Annotated* 602 (1962 Ed).

With respect to the claim of unlawful experimentation, the children most affected are children who are now in public mental hospitals.[5] Neither Jane Doe nor child X are presently in such hospitals. Indeed, not a single plaintiff is presently either an inpatient or the parent of an inpatient in any public mental health facility. Thus, there is no plaintiff who is a member of the class purportedly repre-

[5] Plaintiffs describe as a class, *"children held as inpatients in state mental facilities* [underlining added] who have been or may be subjected . . . to medical experimentation without their consent." (Paragraph 13, Complaint)

sented by the plaintiffs — that is, the class of children who are "inpatients in state mental facilities" — the class upon whom this court's decision will have the greatest impact. Because the named plaintiffs are unlike the class for whom they purport to speak in their research and experiment claim and are not themselves members of this class, we cannot assume that the named plaintiffs will fairly and adequately represent the class.

Let us examine the plaintiffs' claim concerning admissions of children to mental hospitals as it relates to the class suit issue. The defendants argue that with the safeguards provided by the new Mental Health Code, admission of a child to a mental hospital without a judicial hearing and without the child's informed consent is lawful if the parents give informed consent. The plaintiffs argue that hospitalization of children with the informed consent of their parents but without either the informed consent of the children or judicial approval is unconstitutional.[6] As the issue is drawn, the class for whom the plaintiffs necessarily seek relief is the class of children hospitalized on the basis of their parents' informed consent but without the child's informed consent and without "judicial or administrative review."

None of the named plaintiffs has ever been a member of this class. Not a single plaintiff is the child of a parent who gave informed consent to the child's hospitalization. The plaintiffs allege that the mother of plaintiff, child X, did not give voluntary or informed consent. The plaintiffs

[6] Paragraph 25 of plaintiffs' amended complaint recites that ". . . children in the subclass have not been confined as mentally ill persons *after judicial or administrative review* but have been subjected to institutionalization *upon the written agreement of their parents or legal guardians* and the receiving state mental health facility." (Emphasis added)



allege that child Jane Doe was a ward of the probate judge, who was "responsible" for her hospitalization. It is not alleged that there was no "judicial or administrative review" before Jane Doe's hospitalization. The Probate Court must have approved of her placement at Lafayette Clinic. Thus, we have no plaintiff who was ever admitted to a public mental health facility with the informed consent of the parent but without "judicial or administrative review." In the case of one child, there was such "review." In the case of the other child, informed parental consent was lacking.

Respecting the plaintiffs' admissions claim, the relief sought for the members of the putative class, who are inpatients in public mental hospitals, is their release from these hospitals. As mentioned earlier, no named plaintiff is presently an inpatient in a state mental hospital. Thus, the named plaintiffs are not members of the class upon whom this court's decision will have the greatest impact.

More to the point, if the plaintiffs get the relief prayed, the judgment would order release from public mental hospitals of all children who are now in such hospitals with their parents' informed consent, but without their own informed consent and without court approval. But there is no named plaintiff child who was ever admitted to a public mental hospital with his parents' informed consent but without either his own or the court's consent. As noted earlier, one of the two named minor plaintiffs entered the hospital without her parents' informed consent. The other minor plaintiff entered with the approval of a probate judge.

With respect to the hospital admissions claim, we are simply without plaintiffs who are, or who have ever been, members of the class for whom they purport to speak: the

class of children admitted to state mental health facilities upon a consensual arrangement between their parents and officials of the public hospital, but without the informed consent of the children and without judicial approval.

This court cannot assume that all members of this class of children purportedly spoken for by the named plaintiffs would be adequately represented by plaintiffs, who are not even actual members of the class for whom they seek to speak.[7]

Regarding the claim concerning access to hospital records, the persons most concerned are children in public mental hospitals who would be subjected to such research and experimentation and their parents. The pertinent class, therefore, is the class of children who are in public mental hospitals and their parents. No named plaintiff is presently either a child in a public mental hospital, or a parent of such a child. Again, we have the situation in which no plaintiff is a member of the class for whom he seeks to speak.

It is no answer to say that the named plaintiffs are represented by brilliant and assiduous lawyers who will ably advocate for the class. Under General Court Rule 208, it is the parties, and not their lawyers, who are pivotal in determining whether the putative class will be adequately represented by the named plaintiffs.

That the law makes the party the touchstone, rather than his lawyer, should surprise no one. The lawyer is a mere agent of the party — or should be. The client, not the lawyer, has ultimate control of the lawsuit. The lawyer

[7] "[T]he representatives ha[ve] to be members of the class represented . . ." Foster, "The Status of Class Action Litigation," *Research Contributions of the American Bar Foundation*, 1974, No. 4, p. 20.



can be hired and fired by the client. A party, who has a zealous, skillful lawyer today, may have a lackadaisical, inept lawyer tomorrow.

The guarantee of adequate representation lies in the similarity between the named plaintiff and the members of the class he purports to represent. Where this similarity exists there is a likelihood of identity of interest between the named plaintiff and the persons for whom the plaintiff claims to speak. The law rests on the common sense observation that self-interest is a strong motivating force. Where the named plaintiff and the members of the putative class are alike, the plaintiff's self-interest is apt to be the same as the self-interest of the class members who will be effectively benefited or bound by the outcome of the case. In this lawsuit, there is lacking such a similarity of interest between the named plaintiffs and the members of the putative class.

For still another distinct reason, the plaintiffs' complaint regarding research and experimentation is not a proper class action. There can be such great variation in the kinds of experimentation and research done in public mental hospitals that one can hardly say that all children who may be subjected to any kind of research or experimentation in public mental hospitals are similarly situated. One can conceive of experiments which are dangerous, and others which are not. The subjects of such different kinds of experimentation are not similarly situated and are hardly in the same class. It would not be right to make a rule in a case involving innocuous or benign experiments which could, as a practical matter, effectively bind or become a precedent applicable to patients who are subjected to experiments of a dangerous nature. Vice versa, it would be wrong to make a rule in a case dealing with a life-

threatening experiment which could bind, or become a precedent applicable to patients who are subjected to wholly safe experiments.

Similarly, the potential benefit to the patient who is the subject of the research may vary case by case. In those situations where the potential danger to the patient from the research is slight and the potential benefit is great, the patient is not in a situation similar to that of the patient for whom the potential benefit is slight and the potential danger great.

We need not and do not reach or decide the question of whether potential benefit to society is to be weighed in the balance. However, if potential benefit to society is relevant, we have one more variable in which a given plaintiff's case could be unlike the cases of other minor children who might be subjected to experiments or research.

Where such potential dissimilarity exists between the putative spokesman and those spoken for, a class suit is improper.

There is still another distinct reason for refusing to treat the plaintiffs' admission claim as a class suit. For a proper class action, the parties who file the complaint must have essentially the same grievance and must want essentially the same relief as the people they represent. If the people they claim to represent are not likely to have essentially the same sense of grievance as the named plaintiffs or are not likely to want essentially the same relief, the complaint is not a proper vehicle for a class suit.

Respecting the plaintiffs' claim that children should not be admitted to mental hospitals upon the sole consent of their parents without a judicial hearing—is there good reason to believe that there are substantial numbers of children, similarly situated, who share the plaintiffs' sense



of being aggrieved and who share the plaintiffs' desire for relief?

The question could be answered affirmatively if the declaration of rights sought by plaintiffs was indubitably a benefit for children. But this is open to debate and cannot be assumed.

The plaintiffs seek, as a prerequisite for the admission of children to public mental hospitals, the informed consent of the children or court approval, after a hearing. If plaintiffs' goal is achieved, it would be necessary in virtually all cases to create a permanent public record of mental or emotional infirmity before a child could be admitted to a public mental hospital for treatment. It is difficult to imagine a situation in which a minor's consent would be so clearly an informed consent that no judicial test would be necessary. Even if the child voluntarily consented, there would have to be a judicial hearing to test the information, understanding and freedom of choice which the child had in arriving at the decision to enter the hospital. If the child did not consent, there would have to be a hearing before a probate judge to determine whether the child should be admitted to a public mental hospital against his or her will.

Under the laws of Michigan as they now stand, such court proceedings would result in a permanent, public record. Thus, the judicial relief prayed by plaintiffs would, in virtually every case, result in a minor child acquiring a permanent public record of mental or emotional infirmity. Can one assume that few or no children would look askance at the possibility of such a record—a record which could interfere with the child's opportunity to work at a desirable job or to study in a desirable school or college? Can we assume that few or no children would view with

alarm the stigma which could possibly arise from a permanent, public record of mental or emotional infirmity? Many children might see the plaintiffs' victory not as a blessing, but as a curse. One can readily imagine some children saying to the plaintiffs, "If you want to help us, drop your lawsuit."

This is not like the suit in which the goal of those filing the complaint is with very great likelihood shared by those for whom the named plaintiff seeks to speak. Such is the case where plaintiff seeks an award of money, or seeks recognition of a right which is very likely to be desired also by those for whom he speaks.

We cannot find that it is more likely than not, that most, or all children, or even a large number of children, share the pseudonymous plaintiffs' sense of grievance and desire for relief. This being the case, the plaintiffs' complaint respecting admission of children to public mental health facilities cannot be treated as a class suit for and on behalf of children in general.

I conclude that the plaintiffs' complaint is not an appropriate vehicle for a class suit with respect to the claims concerning admission of children to state mental health facilities, research and experimentation on such children, and access to the records of state mental health facilities. However, this does not call for a judgment of dismissal. While the named plaintiffs may not represent others, they may speak for themselves.

The proposition is well established that courts should not decide constitutional issues if the case can be fairly resolved without reaching the constitutional questions. Because this court holds that the plaintiffs' complaint is not appropriate for a class action, it is not necessary



to reach or decide whether treatment of this case as a class suit would violate the due process rights of the members of the putative class.

## V—THE TAXPAYERS' CLAIM

The Intervening Defendant, Michigan Association for Emotionally Disturbed Children, has moved for a summary judgment dismissing the complaint of the plaintiff-taxpayers. The ground most strongly urged for such summary judgment is that the complaint's prayer for relief does not seek to enjoin any expenditure of public funds.

I know of no appellate decision which requires a prayer for such an injunction in order to maintain a so-called taxpayers' suit and none has been brought to my attention. The statute[8] simply provides:

> "[A]n action to prevent the illegal expenditure of state funds or to test the constitutionality of a statute relating thereto may be brought . . . in the names of at least 5 residents of this state who own property assessed for direct taxation by the county wherein they reside."

The taxpayer-plaintiffs would seem to qualify. The courts have by interpretation added a requirement to the statute. It is that the "taxpayer-plaintiffs" must have a genuine economic stake in the outcome. *Menendez* v *City of Detroit*, 337 Mich 476 (1953); *Thomson* v *City of Dearborn*, 349 Mich 685 (1957); *Baker* v *City of Grand Rapids*, 142 Mich 637 (1906); *Westen* v *City of Allen Park*, 37 Mich App 121 (1971).

Since the only interest on which taxpayers can predicate standing is their economic interest, if victory in the suit

[8] MCLA 600.2041(3)

would not be to their economic advantage, the taxpayers would not have an interest which would give them standing.

In the instant suit, it may well be that the taxpayers will lose by winning. If plaintiffs prevail, court proceedings will be required in virtually every case in which a child is admitted to a public mental hospital. Query whether the cost to the taxpaying public of such litigation would not exceed the public funds saved in the administration of mental hospitals by regulating admissions of children in the manner prayed by the plaintiffs. But the answer depends upon evidence which is not in the record at this stage of the proceedings. Thus, this court cannot rule, at this stage of the proceedings, that the taxpayer-plaintiffs do not have such a genuine economic interest as would give them standing as plaintiffs.

Moreover, the discontinuance of certain experimentation and research in public mental hospitals would appear, *prima facie*, to result in a saving of public funds. The "taxpayer-plaintiffs," therefore, would seem to have an economic interest in preventing such research and experimentation.

I conclude that the taxpayers have standing and have stated a claim upon which relief can be granted. But this does not mean that the taxpayers' claim must be tried along with the children's claim. The taxpayers' claim should be severed from the other claims of the plaintiffs and should be tried separately for the reasons which follow.

The taxpayers' claim and the claims on behalf of the children are misjoined. The taxpayers' claim is so different in nature and inspired by objectives so different from those of the other plaintiffs that the joinder results in a multifariousness of issues and parties. The joinder of the taxpayers' claim with the claims of the other plaintiffs



on behalf of children complicates and confuses the issues. Such joinder does not contribute to the pursuit of justice.

The old common law objection to multifarious pleading is still available, (Callaghan, *Michigan Pleading and Practice*, Sec. 21.34, p 33), although the relief is no longer dismissal. The modern remedy is severance under General Court Rules 203, 206, 207, and 505, that is, the separation of parties and issues, and the provision for separate trials.

Therefore, although the taxpayers' complaint states a claim for which relief may be granted, their claim should be severed from and tried separately from the claims of the other plaintiffs.

Incidentally, it should not be assumed that this judge will try the taxpayers' claim or the other claims. Under the Wayne County Circuit Court practice, only the presiding judge may order the case tried by the judge to whom it was originally assigned, and the presiding judge does not rule until all the parties have been given an opportunity for a hearing.[9]

## VI—THE ACTUAL CONTROVERSY ISSUE CONCERNING ADMISSIONS

Plaintiffs' suit is, in essence, a suit for a declaratory judgment governed by General Court Rule 521. General Court Rule 521 is the successor to two statutes. The first declaratory judgment statute was held unconstitutional in 1920 as an attempt to confer non-judicial powers on the judiciary. The Michigan Supreme Court reasoned that the statute called upon courts to dispose of matters which

[9] Habeas corpus hearings are conducted traditionally by the judge who signed the writ. Although this case was started as a petition for a writ of habeas corpus, it is more correctly characterized as a declaratory judgment action and the plaintiffs have so conceded on the record in open court.

were not actual controversies, and which were not, therefore, within the power conferred by the Constitution on the courts. *Anway* v *Grand Rapids Ry Co,* 211 Mich 592.

Subsequently, the Legislature enacted another declaratory judgment statute which was upheld, when Michigan's high court interpreted it as requiring an actual controversy for exercise of the court's declaratory judgment jurisdiction. *Washington-Detroit Theater Co* v *Moore,* 249 Mich 673 (1930). The 1963 General Court Rules replaced the latter statute, which was repealed by the Revised Judicature Act.

The history of declaratory judgments in Michigan makes one point clear: The Courts of Michigan take very seriously the requirement of an actual controversy as a condition precedent to an assertion of the court's jurisdiction to grant declaratory relief. *McLeod* v *McLeod,* 365 Mich 25 (1961); *McMullen* v *Alger,* 339 Mich 175 (1954); *Johnson* v *City of Muskegon Heights,* 330 Mich 631 (1951); *City of Detroit* v *Div 26, Amalgamated Association of St., Elec., Ry. & Motor Coach Employees,* 332 Mich 237 (1952); *City of Flint* v *Consumers Power Co,* 290 Mich 305 (1939); *School District No. 1* v *School District, City of Lansing,* 331 Mich 523 (1951); *Finlayson* v *West Bloomfield Twp,* 320 Mich 350 (1948); *Village of Grosse Pointe Shores* v *Ayres,* 254 Mich 58 (1931); *Washington-Detroit Theater Co* v *Moore,* 249 Mich 673 (1930).

General Court Rule 521.1 provides:

> "In a case of *actual controversy* within its jurisdiction, any circuit court . . . may declare the rights and other legal relations of any interested party seeking a declaratory judgment whether or not other relief is or could be sought or granted." (Underlining added)



The plaintiffs' claim regarding admission of children to public mental hospitals does not satisfy the jurisdictional requirement that there be an actual controversy.

The principal issue which the plaintiffs seek to raise is whether a child who does not give informed consent to his admission to a public mental hospital may be lawfully admitted upon his parents' informed consent, without a court hearing. There is no genuine or actual controversy regarding this issue because there is no child, who is a party in this case, who has ever been admitted to a public mental hospital upon his parents' informed consent, but without his own informed consent and without court approval.

Admittedly, plaintiff, child X, did not have a court hearing before being hospitalized at Lafayette Clinic. However, according to the plaintiffs' allegations, child X was not admitted to Lafayette Clinic with her mother's informed consent but on the basis of her mother's uninformed, coerced consent. (No party to this lawsuit contends that an admission of a child to a public hospital would be lawful without the informed consent of either the child, the parents, or the court).

According to the plaintiffs' allegations, the other child named as a plaintiff, Jane Doe, was a ward of the Probate Court, Juvenile Division. Nowhere do plaintiffs allege that the Probate Court did not determine that its ward, Jane Doe, should enter a public mental hospital. Indeed, paragraph 9 of the complaint alleges that the Juvenile Division of the Probate Court is responsible for the placement of Jane Doe in the Lafayette Clinic. She could not have been admitted to a public mental hospital without a court passing on the matter. One plaintiff child was admitted without her parents' informed censent. The

other child was admitted after a determination by the Probate Court. No minor plaintiff has ever been, personally or directly, a participant in an actual controversy over the admission of a child to a public mental hospital without the child's consent and without court approval, but with the informed consent of the parents and the hospital. And no adult plaintiff is the parent of a child who has ever been an actual participant in such a hospital admission controversy.

In short, in this case there are no parties to a real controversy over admissions without the informed consent of the child and without a judicial determination, but with the informed consent of the parents. Without actual parties to a controversy, there cannot be an actual controversy.

The court is asked to redress a grievance not actually experienced by any of the parties. The court is called upon to resolve a theoretical, academic, or philosophical dispute, but not to decide an actual controversy between live litigants asserting their own experienced grievances. This, a court has no authority to do. *Washington-Detroit Theater Co* v *Moore*, 249 Mich 673.[10]

Another analytical approach, based on the standing of the parties, leads to the same result. A child, like child X, who was admitted to a public mental hospital without informed consent by her parents, has no standing to challenge admission of children based on their parents' informed consent.

A child, such as Jane Doe, who was admitted to a public mental hospital with the approval of a probate judge, has

[10] "That the [Declaratory Judgment] act does not constitute a court a fountain of legal advice . . . is also amply sustained by judicial opinion." *Washington-Detroit Theater Co* v *Moore, supra*, at 673.



no standing to challenge admissions which have not been approved by a probate judge.

Whether we search for an actual controversy or for standing, we cannot find an appropriate basis for asserting the court's declaratory judgment jurisdiction concerning the issue of admissions of children to public mental facilities on the basis of their parents' informed consent, without their own informed consent and without a judicial determination. In connection with such admissions to public mental hospitals, we seem to have lawyers with a burning cause, but without a burnt client. Such abstract, philosophical disputes are for the classroom, and the arena of political debate but not for resolution by the courts. *Johnson* v *City of Muskegon Heights*, 330 Mich 631; *School District No. 1* v *School District, City of Lansing*, 331 Mich 523; *Washington-Detroit Theater Co* v *Moore*, 249 Mich 673.

I conclude as a matter of law that except for the taxpayer-plaintiffs, the plaintiffs do not present an actual controversy concerning the admissions issue, and do not present any parties with standing to raise it. It is not enough to say that somewhere there must be people who are participants in such an actual controversy. The named plaintiffs are not, and they cannot rely on unnamed and unknown people to make an actual controversy.

For these reasons, the court holds that the defendants are entitled to a partial summary judgment of dismissal respecting the plaintiffs' claim of unlawfulness in the admission and hospitalization of minor children in state mental health facilities. This holding is not applicable to the taxpayers' claim which should be severed and dealt with, separately.

## VII—THE ACTUAL CONTROVERSY ISSUE CONCERNING RESEARCH

There is a close question as to whether the plaintiffs' research and experimentation claim presents an actual controversy. In declaratory judgment actions, courts have been strict in their avoidance of moot issues.[11] In the case at bar, there is no named plaintiff who is now in a public hospital where he or she is, or might be, the subject of experimentation or reseach. Nevertheless, two or the named plaintiffs were, at one time, patients in public mental hospitals where, it is alleged, staff physicians sought to subject them to experimentation or research without the childrens' informed consent and without prior court approval. The experimentation and research claim differs from the admissions claim. No named plaintiff was ever admitted to a public mental health facility without his or her own informed consent but with the informed consent of a parent or parents. On the other hand, named plaintiffs have allegedly been admitted to such facilities and certain defendants allegedly sought to use them as subjects of research and experiments.

In recent years high appellate court decisions have broadened the latitude which the courts have in deciding whether issues are moot. *US* v *Grant Co,* 345 US 629; *Woodson* v *Dept of Social Services,* 27 Mich App 239 (1970); *Lafayette Dramatic Products, Inc* v *Ferentz,* 305 Mich 193 (1943).

The mere cessation by a defendant of allegedly unlawful conduct does not necessarily render a case moot, absent a showing by the defendant that the disputed activity will never again occur. *US* v *Grant Co,* 345 US 629.

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[11] See the cases cited, supra, page 19.



In view of the allegation that physicians in public hospitals sought to subject certain children to research and experiments without their informed consent and without court approval, the issue of the lawfulness of such a practice by the personnel of public hospitals is appropriate for judicial resolution even though the children are no longer in such hospitals.

This court holds that the issues raised by the plaintiffs' research and experimentation claim are not moot. Further, this court holds that there is an actual controversy regarding the plaintiffs' research and experimentation claim.

As earlier indicated, the claim of the taxpayer-plaintiffs respecting research and experimentation should be dealt with separately.

## VIII—SUMMARY JUDGMENT INAPPROPRIATE ON RESEARCH CLAIM

There are disputed issues of material facts respecting the plaintiffs' experimentation and research claim, and, for this reason, the court cannot determine as a matter of law whether any of the parties should prevail. For this reason summary judgment is inappropriate. Among the disputed issues are the following: Whether certain of the experimentation and research alleged by the plaintiffs has taken place and whether it is likely to take place in the future; whether or not such experimentation involves risks or burdens to the children who are subjected to it; the extent of such risk or burden, if any; whether there is potential benefit to the patient from the alleged research or experimentation; the extent of such potential benefit, if any; whether or not there is potential benefit to the public[12]

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[12] The court does not decide whether potential benefit to the public is a relevant factor in determining whether the research in question is lawful.

from the alleged research; the extent of such potential benefit, if any; and whether certain procedures are or are not properly characterized as non-therapeutic research.

Thus, this is not a case in which it can be said that there is no genuine issue of material fact and that either the plaintiffs or the defendants are entitled to judgment as a matter of law.

Nor is this a case in which the plaintiffs have failed to plead a case in which relief can be granted. Plaintiffs allege, *inter alia,* that children in public mental health facilities have been subjected by certain of the defendants to research and experimentation without the consent of their parents or persons *in loco parentis,* without the consent of the children, and without the consent of any court; that the consent of the children to such experimentation is never sought by the defendants; that the experimentation to which the children are subjected can be extremely harmful; that the benefit to the children who are the subjects of experimentation is nill or slight; that the possible side effects of such experimentation are not known; that the experiments are of dubious value as a basis for any scientific conclusions.

These allegations state a claim for which relief can be granted. I conclude, therefore, that the plaintiffs' claim regarding research and experimentation withstands the defendants' motion for sumary judgment.

## IX—THE RECORDS CLAIM

The plaintiffs' third distinct claim concerns their right to receive records and documents from public mental health facilities relating to medical experimentation and research.

This matter is regulated by statute, (MCLA 24.201; MSA 3.560(101)), which provides:



> "The circuit court for the county in which the agency records are situated may order, on petition of any person, the production of any identifiable material improperly withheld from public inspection and copy." MCLA 24, 223(2); MSA 3.560(123)

Nowhere in the complaint can one find allegations that a request for identifiable material was made by any of the plaintiffs. Such a request is a prerequisite to a cause of action. *Bristol-Meyers Co* v *FPC,* 424 F 2d 935 (DC Cir, 1970); *Citizens for Better Care* v *Dept of Public Health,* 51 Mich App 474 (1974); *Irons* v *Schuyler,* 465 F 2d 609 (DC Cir, 1972).

A partial summary judgment is granted the defendants, dismissing the plaintiffs' claim regarding access to public records, because the plaintiffs' complaint in this regard fails to state a claim on which relief can be granted.

## X—CONSTITUTIONALITY OF MENTAL HEALTH CODE

In view of the holding that the plaintiffs' claim concerning admissions to public mental hospitals does not present an actual controversy, this court has no occasion to rule on the constitutionality of the provisions of the new Mental Health Code, which govern admissions of minor children to state mental hospitals and their release.

The defendant, Association, should prepare an order of partial summary judgment in accordance with this opinion, dismissing the plaintiffs' hospital admissions claim for lack of an actual controversy. The order should deny the motion for a partial summary judgment in defendants' favor on the admissions and research claims. It should deny the defendants' motion for summary judgment on the plain-

tiffs' research and experimentation claim. It should dismiss the praecipe for the partial summary judgment motion of the Michigan Department of Mental Health with a finding that there is no occasion to pass upon the constitutionality of the new Mental Health Code in view of the dismissal of plaintiffs' admission claim. The order should provide for a partial summary judgment of dismissal of the plaintiffs' claim concerning access to medical records.

The order should provide for severance and separate trial of the taxpayers' claim.

No costs are to be awarded, no party having wholly prevailed and the issues being close, complex, and novel.

/s/ VICTOR J. BAUM
Circuit Judge

A True Copy
JOSEPH B. SULLIVAN
Clerk
/s/ E. CINSELL
Deputy Clerk

Dated at Detroit, Michigan,
October 29, 1974.



IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

TOM WOJCIEHOWSKI, Next Friend of JOHN DOE, a minor, on behalf of JOHN DOE and all others similarly situated,*

Plaintiffs, No. 75-72318

vs. JUDGE

THE DIRECTOR OF THE MICHIGAN DEPARTMENT OF MENTAL HEALTH, In his official capacity, and his successors, assignees, employees and agents; VERNON STEHMAN; WILLIAM KIRK; and HARVEY DAY, in their official capacities as employees and agents of Ypsilanti State Hospital and the Michigan Department of Mental Health, CORNELIA G. KENNEDY

Defendants.

COMPLAINT FOR INJUNCTIVE, DECLARATORY AND CLASS ACTION RELIEF REQUIRING CONSIDERATION BY A THREE-JUDGE COURT

## I. PRELIMINARY STATEMENT

1. Plaintiff, a minor, brings this action on his own behalf and on behalf of all persons in Michigan under 18 years of age who have been, are or will be placed in public mental health facilities under the Formal Voluntary Admissions sections of the new Michigan Mental Health Code,

*This action was originally filed in the name of the nominal plaintiff. The Court amended the title of the case to protect the child and his parents from further public stigmatization and embarrassment. Throughout the complaint, language that identifies the child or his parents has been removed and replaced with three asterisks.

since November 6, 1974, the date the pertinent provisions of said statutes took effect. Plaintiff challenges the constitutionality of those Code sections, MCLA 330.1415-1420, which permitted his parents to have him institutionalized without any showing that he consented to such hospitalization, and without a hearing to determine whether he is mentally ill and dangerous *before* he was committed against his will.

Plaintiff seeks to have the Michigan Statutes allowing parents to hospitalize and treat him against his will enjoined, and declared unconstitutional insofar as they permit the forced hospitalization of persons under 18 years of age without due process or equal protection of the laws as guaranteed by the Fourteenth Amendment to the United States Constitution and as specifically required by the decisions of this Court in *Bell* v *Wayne County General Hospital*, 384 F Supp 1085 (ED Mich 1974) and the decision of the Michigan Courts in *Kaimowitz* v *Department of Mental Health*, Civ. No. 73-19434-AW (Cir Ct of Wayne County, Mich, July 10, 1973).

## II. JURISDICTION

2. This is a suit for declaratory and injunctive relief authorized by Title 42 USC §1983 to be commenced by any citizen of the United States, or other persons within the jurisdiction thereof, to redress the deprivation under color of statute, ordinance, regulation, custom or usage of rights, privileges and immunities secured by the Constitution and the law of the United States. The rights, privileges and immunities sought herein to be redressed are those secured by the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the Constitution of the United States.



3. The jurisdiction of this Court is invoked pursuant to Title 28 USC §1343(3) and (4). Injunctive and declaratory relief is requested pursuant to Title 28 USC §2201 and §2202 and as authorized by Tile 42 USC §1983.

4. This is a proper cause for determination by a three-judge court pursuant to Title 28 USC §2281 and §2284, since Plaintiff seeks to enjoin the Defendants and other public officials from the enforcement, operation, application and enactment of state statutes providing for the formal voluntary admission of persons under 18 years of age into a hospital for in-patient treatment of persons who are mentally ill, namely MCLA 330.1415-1420, since the challenged provisions deny such persons as are affected by it rights guaranteed to them under the United States Constitution.

## III. PARTIES

5. Plaintiff, * * * , is an 11-year-old citizen of the United States. He currently is incarcerated pursuant to the Formal Voluntary Admission provisions of the Michigan Mental Health Code at York Wood Center for Children at Ypsilanti State Hospital [hereinafter York Wood Center].

6. Plaintiff's next friend, Tom Wojciehowski, is a 24-year-old citizen of the United States, who resides at 788 Watersedge Drive, Ann Arbor, Michigan. Mr. Wojciehowski first became acquainted with Plaintiff when he was employed as a student teacher and child care worker at York Wood Center from August, 1972 through November, 1973. Further, Mr. Wojciehowski, at Plaintiff's parents' request, continued to work with Plaintiff for 5-8 hours per week as Plaintiff's "Big Brother" in a special program at

said York Wood Center from November, 1973 until May, 1975. Mr. Wojciehowski is currently employed as an educational supervisor at Family Group Homes for Youth, Inc., 2500 Packard Road, Ann Arbor, Michigan, and completing his studies for a masters degree at Eastern Michigan University.

7. Defendant, Director of the Michigan Department of Mental Health, has the administrative responsibility for implementing and enforcing the Michigan Mental Health Code; said code includes the statutes in question herein, MCLA 330.1415-1420, which authorize the formal voluntary admission of persons under 18 years of age into hospitals for in-patient treatment as mentally ill persons. Defendant, Director of the Michigan Department of Mental Health, is directly responsible for the operation, administration, and treatment provided to residents of Michigan mental health facilities, including York Wood Center. Donald C. Smith currently occupies this position.

8. Defendant, Vernon Stehman, is the Director of Ypsilanti State Hospital, and an agent and employee of Defendant, Donald C. Smith, Director of the Michigan Department of Mental Health. Defendant Stehman is responsible for the operation, administration and treatment provided to residents at Ypsilanti State Hospital, including the York Wood Center for Children.

9. Defendant, William Kirk, is the Director of York Wood Center, and is an agent and employee of Defendant, Donald C. Smith, Director of the Michigan Department of Mental Health. Defendant Kirk is responsible for the operation, administration and treatment provided residents at York Wood Center.



10. Defendant, Harvey Day, is Acting Director of In-Patient Services at York Wood Center, and an agent and employee of Defendant, Donald C. Smith, Director of the Michigan Department of Mental Health. Defendant Day is responsible for the operation, administration and treatment provided residents who are in-patients at York Wood Center.

## IV. CLASS ACTION

11. Plaintiff, * * * , brings this action on behalf of himself and all other persons similarly situated pursuant to Rule 23(a), 23(b)(1) and (b)(2) of the Federal Rules of Civil Procedure. He seeks, on behalf of himself and other members of the class, injunctive and declaratory relief arising from a cause of action under 42 USC §1983.

12. The class consists of all persons under 18 years who have been, now are or will be admitted to hospitals for the in-patient treatment of persons who are mentally ill under the Formal Voluntary Admission sections of the Michigan Mental Health Code, MCLA 330.1415-1420.

13. The persons constituting said class are so numerous that joinder of all members is impracticable.

14. There are questions of law and fact common to the class.

15. The claims of the named Plaintiff are typical of the claims of the class insofar as the members are persons under 18 years of age who are detained under the Formal Voluntary Admission sections of the Michigan Mental Health Code, and as a result are deprived of due process and equal protections of the law as guaranteed to them by

the Fourteenth Amendment to the United States Constitution. The injunctive and declaratory relief Plaintiff seeks is equally applicable to all members of the class.

16. The named Plaintiff will fairly and adequately protect the interests of the class.

17. The prosecution of separate actions by individual members of the class for the purposes stated above would create a risk of: (a) inconsistent or varying determinations with respect to individual members of the class which would establish incompatible standards of conduct for the Michigan Defendants, and (b) determinations with respect to individual members of the class which would, as a practical matter, be dispositive of the interests of the other members who would not be parties to the determinations and substantially impede their ability to protect their interests.

18. The Defendants have acted or refused to act on grounds generally applicable to the class, thereby making appropriate preliminary and final injunctive relief and corresponding declaratory relief with respect to the class as a whole.

## V. STATEMENT OF FACTS

19. On or about February 25, 1975, Plaintiff's father, * * *, of * * *, Michigan, executed a Formal Voluntary Admission Application as provided in MCLA 330.1415-1420, requesting that Plaintiff herein, his son, be admitted to "Ypsilanti State Hospital—York Wood Center." A copy of said Application is attached hereto and incorporated herein as Plaintiff's Exhibit A.

20. On information and belief, no Court hearing of any kind was held prior to Plaintiff's formal voluntary admission to York Wood Center.



21. On information and belief, Plaintiff objected to his hospitalization at York Wood Center both prior to said formal voluntary admission and subsequent to that date.

22. On or about February 25, 1975, Plaintiff's next friend, Tom Wojciehowski, also received a copy of said Formal Voluntary Admission pursuant to Plaintiff's request and as authorized by MCLA 330.1415-1420. A copy of a letter to Mr. Wojciehowski which accompanied said papers is attached hereto and incorporated herein as Plaintiff's Exhibit B.

23. Mr. Wojciehowski was not informed of his right to object to Plaintiff's incarceration, nor at that time did he consider himself to be an appropriate person to make objections since he had no legal rights to Plaintiff. A copy of the Affidavit of Tom Wojciehowski is attached hereto and incorporated herein as Plaintiff's Exhibit C.

24. Since Plaintiff was not removed from York Wood Center, and Mr. Wojciehowski believed that Plaintiff was neither mentally ill nor dangerous, Mr. Wojciehowski wrote a letter to Defendants Stehman, Kirk and others, detailing his objections to Plaintiff's confinement at York Wood Center. A copy of said letter is attached hereto and incorporated herein as Plaintiff's Exhibit D.

25. As a result of Mr. Wojciehowski's objections to Plaintiff's incarceration, on May 20, 1975, Defendant Day terminated Mr. Wojciehowski's relationship as Plaintiff's "Big Brother;" thus, preventing Mr. Wojciehowski from further communicating with Plaintiff.

26. On or about May 30, 1975, at the request of Mr. Wojciehowski, Attorney Thomas Darnton of Washtenaw

County Legal Aid Society, visited Plaintiff at York Wood Center.

27. During said visit, Plaintiff on several occasions expressed his clear desire to be removed from York Wood Center and indicated his wish that Attorney Darnton aid him. A copy of Attorney Darnton's Affidavit is attached hereto and incorporated herein as Plaintiff's Exhibit E.

28. On or about September 30, 1975, Attorney Rose Marie Adamo of Legal Services of Eastern Michigan, visited Plaintiff at York Wood Center.

29. During said visit, Plaintiff again expressed his clear and continuing desire to be removed from York Wood Center and indicated that he continued to want Attorneys Darnton and Adamo to aid him. A copy of Attorney Adamo's Affidavit is attached hereto and incorporated herein as Plaintiff's Exhibit F.

30. As of this date, despite his objections and those of Mr. Wojciehowski, Plaintiff, * * * , remains incarcerated at York Wood Center and has not received a hearing before any Michigan Court or tribunal where he can contest said confinement.

31. All Defendants have acted under color of their official capacity and the authority they believe they have under the Michigan Mental Health Code and Michigan law to deprive Plaintiff and the class he represents of rights guaranteed to them under the Fourteenth Amendment to the United States Constitution.

## VI. EQUITY

32. The Plaintiff, * * * , and the class he represents, have no plain, adequate or complete remedy at



law to redress the stated constitutional deprivations and wrongs; the Plaintiff, and the class he represents, will continue to suffer irreparable harm from the constitutional deprivations and wrongs set forth herein, unless and until the declaratory and injunctive relief sought herein is granted by this Court.

## VII. CLAIM

33. Plaintiff realleges herein paragraphs one (1) through thirty-two (32), as set forth above.

34. Plaintiff, * * * , and the members of the class he represents, are currently subjected to incarceration, forced chemotherapy, stigmatizing hospital records and arbitrary transfers in, to and from hospitals for the in-patient treatment of persons who are mentally ill under the Formal Voluntary Admission section of the Michigan Mental Health Code, MCLA 330.1415-1420.

35. Plaintiff, * * * , and the class he represents, are, pursuant to MCLA 330.1415-1420, subjected to said confinement for indefinite lengths of time up to their 18th birthdays and some undetermined period thereafter without judicial hearings prior to or simultaneous with their confinement, to determine:

a. whether they have formally volunteered for admission (i.e., whether they have given informed, knowing and voluntary consent to such incarceration, a determination required by the United States Constitution and court decisions if they were persons over 18 years of age who were formal voluntary admissions to such hospitals as described herein), or

b. whether they are to be involuntarily held as persons who are mentally ill and requiring treatment as defined under the Michigan Mental Health Code.

36. Plaintiff, • • • , and the class he represents, state a cause of action under Title 42 USC §1983 for the deprivation of their civil rights by the named Defendants; said deprivation can only be completely remedied by the enjoining of the enforcement of MCLA 330.1415-1420 and declaring them to be unconstitutional on their face.

37. Said statutes are unconstitutional and deprive Plaintiff and the class he represents of their civil rights insofar as said laws:

a. permit extensive deprivation of liberty of persons under 18 years of age without due process of law;

b. deny equal protection of the law to persons under 18 years of age, as compared to persons over 18 years of age;

c. permit incarceration of such persons under 18 years of age under a standard of "clinical suitability" which is so general, vague, indefinite and overbroad that it does not sufficiently inform those subject to the Formal Voluntary Admission provisions of the Michigan Mental Health Code of the acts or omission which will subject them to in-patient treatment and hospitalization, or provide a meaning which persons of common intelligence can understand and apply equally when they are hospitalizing persons under 18 years of age pursuant to the Michigan Mental Health Code;

d. subject persons to cruel and unusual punishment by stigmatizing them, forcing treatment upon them without any standards or control and institutionalizing them without any determination that they are in fact mentally ill or persons requiring treatment under the Michigan Mental Health Code provisions applicable to persons over 18 years of age;



e. permit invasion of privacy and intrusion into the First Amendment rights of persons under 18 years of age without first providing for judicial determinations that these persons under 18 years of age are in fact mentally ill or persons requiring treatment under the Michigan Mental Health Code provisions applicable to persons over 18 years of age.

## VIII. PRAYER FOR RELIEF

WHEREFORE, Plaintiff, • • • , on behalf of himself and the class he represents, prays that this Court:

1st. Assume jurisdiction of this cause and set it down promptly for a hearing pursuant to 28 USC §2284 before a three-judge court, and determination pursuant to Rule 23(c)(1) of the Federal Rules of Civil Procedure that this cause be maintained as a class action.

2nd. Preliminarily and permanently enjoin the enforcement and operation of MCLA 330.1415-1420 and declare said statutes to be unconstitutional pursuant to Rules 57 and 65 of the Federal Rules of Civil Procedure and Title 82 USC §2201, §2202, §2281 and §2284 so as to prevent the Plaintiff and the class he represents from being incarcerated in hospitals for the in-patient treatment of persons who are mentally ill, subjected to forced chemotherapy, stigmatized by entries on hospital records without prior judicial determinations that they have knowingly and voluntarily consented on an informed basis to such institutionalization or that they are mentally ill and require treatment as defined under the Michigan Mental Health Code.

3rd. Grant Plaintiff, and the members of the class he represents, their costs herein, reasonable attorneys' fees

for their participation in this case in the capacity of private attorney generals, and grant such additional or alternative relief as may be deemed by this Court to be just, equitable and proper.

Respectfully submitted,

Dated: Nov. 24, 1975

/s/Rose Marie Adamo
Attorney for Plaintiff
LEGAL SERVICES OF
EASTERN MICHIGAN
412 Genesee Bank Building
Flint, Michigan 48502
(313) 234-2621

Dated: Nov. 24, 1975

/s/Thomas B. Darnton
Attorney for Plaintiff
WASHTENAW COUNTY
LEGAL AID SOCIETY
130 West Michigan Avenue
Ypsilanti, Michigan 48197
(313) 481-0500

Dated: Nov. 24, 1975

/s/ Gabe Kaimowitz
MICHIGAN LEGAL SERVICES
900 Michigan Building
200 Bagley Avenue
Detroit, Michigan 48226
(313) 964-4130



DMH-2423 EXHIBIT A

MICHIGAN DEPARTMENT
OF MENTAL HEALTH
FORMAL VOLUNTARY ADMISSION APPLICATION

TO: The Director of Ypsilanti State Hospital - York Woods Center

The formal voluntary admission of • • • is requested. The applicant understands that THE HOSPITAL MAY CONTINUE TO HOLD THE INDIVIDUAL UP TO THREE (3) DAYS, NOT INCLUDING SUNDAYS AND HOLIDAYS, AFTER WRITTEN NOTICE OF THE INTENTION TO LEAVE THE HOSPITAL IS GIVEN BY THE PERSON MAKING THIS APPLICATION. THIS WRITTEN NOTICE SHALL BE ON A FORM WHICH WILL BE GIVEN IMMEDIATELY WHEN REQUESTED, OR WHEN THE HOSPITAL IS TOLD OF A DESIRE TO HAVE THE INDIVIDUAL LEAVE THE HOSPITAL.

The applicant also understands that IF THE DECISION TO LEAVE IS NOT CHANGED AND IF THE DIRECTOR OF THE HOSPITAL DECIDES THAT THE PATIENT IS MENTALLY ILL AND, AS A RESULT, THE PATIENT IS LIKELY TO SERIOUSLY PHYSICALLY INJURE HIMSELF OR SOMEONE ELSE OR IS NOT ABLE TO TAKE CARE OF BASIC NEEDS SUCH AS FOOD, CLOTHING OR SHELTER NECESSARY TO AVOID SERIOUS HARM, THE DIRECTOR MAY, WITHIN THREE DAYS, TAKE TO THE PROBATE COURT AN APPLICATION FOR THE CONTINUED HOSPITALIZATION AND TREATMENT OF THE PATIENT, AND THE PATIENT WILL STAY IN THE HOSPITAL PENDING A COURT HEARING.

The applicant understands that the admission is TEMPORARY and that the individual will be released in the community when, in the opinion of the director of the hospital, the individual has made maximum improvement from inpatient care.

The applicant hereby consents to and authorizes the hospital to provide treatment, including medication and chemotherapy, but consent to electroshock, psychosurgery, experimental drugs, and surgical procedures, except surgical and medical procedures of an emergency nature, must be obtained by the hospital in separate consents.

IF THE INDIVIDUAL TO BE ADMITTED IS A MINOR, BOTH THE INDIVIDUAL, IF ABLE TO READ, AND THE APPLICANT MUST READ THE REVERSE SIDE BEFORE SIGNING THE APPLICATION.

The applicant agrees to disclose such information as is required by law to determine financial liability for mental health services. The applicant understands this determination will be made by the Department of Mental Health subsequent to admission and a notice of the determination and appeal procedures will be sent to the applicant as required by Department regulations.

Applicant Information (Must be at least 18 years of age):
Name: • • •
Address: • • •, Mich. 48185
County of Residence: Wayne
Date of Birth: • • •
Phone: • • •
Person to be Admitted (if different from applicant):
Name: • • •
Address: • • •
County of Residence: Wayne



Date of Birth: • • •
Phone: • • •
Signature of Applicant: /s/ • • •
Date: • • •
Relationship to individual: parent
Signature to acknowledge oral explanation of rights set forth in application: Applicant: /s/ • • •
Date: 2-25-75; Individual admitted: (if minor)
/s/ • • • Date: 2-25-75
Signature to acknowledge receipt of copy of application:
Applicant: /s/ • • •, Date: 2-25-75
Individual admitted: (if minor) /s/ • • •
Date: 2-25-75
Person designated by patient to receive copy of application:
Name: Tom Wojciehowski; Address: 7•8 Watersedge;
City: Ann Arbor; State: Mich.; Zip: 48105.
Mailed or given: Feb. 25, 1975.
Action by Hospital: clinically suitable for formal admission
Signed: /s/ Allen K. Thorburn, M.D.; Date: 2-25-75

Your family or guardian and the hospital staff have decided you need to be in a hospital to help solve your problems.

WHEN A PERSON LESS THAN 18 YEARS OF AGE IS PLACED IN A HOSPITAL BY A PARENT OR OTHER GUARDIAN, AN OBJECTION CAN BE MADE. THAT OBJECTION CAN BE EITHER THAT THE PATIENT DOES NOT NEED TO BE IN THE HOSPITAL OR THAT NEEDED TREATMENT WITHOUT BEING IN A HOSPITAL IS AVAILABLE, OR BOTH. THIS OBJECTION IS MADE TO THE PROBATE COURT IN WRITING ON A FORM FROM EITHER THE COURT OR THE HOSPITAL.

IF THE PATIENT IS 13 YEARS OF AGE OR OLDER, HE OR SHE CAN MAKE HIS OR HER OWN OBJECTION. A PERSON THE COURT DETERMINES IS SUITABLE MAY MAKE THIS OBJECTION FOR ANY PERSON LESS THAN 18.

THE OBJECTIONS CAN BE MADE AT THE FOLLOWING TIMES:

1. BEFORE ADMISSION IF ADMISSION HAD BEEN AGREED TO BY THE HOSPITAL BUT DELAYED.
2. DURING THE FIRST 30 DAYS AFTER ADMISSION.
3. AT ANY THREE MONTH PERIOD FROM THE TIME OF THE FIRST OBJECTION OR, IF NO OBJECTION IS MADE EITHER BEFORE ADMISSION OR DURING THE FIRST 30 DAYS, AT ANY THREE MONTH PERIOD FROM THE DATE OF ADMISSION.

WHEN A PATIENT BETWEEN 13 AND 18 TELLS THE HOSPITAL HE OR SHE WANTS TO OBJECT, THE HOSPITAL WILL HELP MAKE THE OBJECTION BY TELLING THE PATIENT WHEN THE OBJECTION CAN BE MADE, PROVIDING THE FORM, HELPING THE PATIENT COMPLETE IT AND SEEING TO IT THAT THE COURT RECEIVES THE OBJECTION. WHEN A PATIENT UNDER 13 INFORMS THE HOSPITAL THAT HE OR SHE WANTS TO OBJECT, THE HOSPITAL WILL NOTIFY THE PROBATE COURT AND REQUEST APPOINTMENT OF A GUARDIAN AD LITEM TO ASSIST THE PATIENT.

A HEARING WILL BE HELD WITHIN 7 DAYS



AFTER THE COURT RECEIVES THE OBJECTION AND THE COURT WILL SEE THAT THE PATIENT'S RIGHTS, SUCH AS A LAWYER, PAID FOR BY THE COURT IF NECESSARY, ARE HONORED.

IF THE COURT AGREES WITH THE OBJECTION, IT WILL ORDER A RELEASE FROM THE HOSPITAL. IF THE COURT DOES NOT AGREE, THE PATIENT WILL STAY AT THE HOSPITAL. THE FACT THAT A PATIENT'S FAMILY OR OTHER GUARDIAN CANNOT OR WILL NOT TAKE CARE OF THE PATIENT WILL NOT STOP THE COURT FROM ORDERING A RELEASE. IF SUCH A SITUATION DOES EXIST, A NEGLECT PROCEEDING WILL TAKE CARE OF THE MATTER. THE OBJECTING PERSON MAY START THIS ACTION IF HE OR SHE WISHES.

In my opinion the person requesting formal voluntary admission of himself/herself is competent to give informed consent to treatment and to execute this agreement.

Signature: M.D.
Date:

The required oral explanation to the individual to be admitted was not given since in my opinion the individual is not in any way capable of comprehending the explanation because .....

Signature: M.D.
Date:

## EXHIBIT B

State of Michigan — Department of Mental Health
William G. Milliken, Governor — E. G. Yudashkin, M.D.
Director

*An Agency of the Department of Mental Health*
YPSILANTI STATE HOSPITAL
3501 Willis Road, Ypsilanti, Michigan 48197
Telephone 313/434-3400
V. A. Stehman, M.D., Superintendent

February 25, 1975

Mr. Tom Wojciehewski
788 Watersedge
Ann Arbor, MI 48105

RE: • • •

Dear Mr. Wojciehewski:

Under the new Mental Health Code, a person being admitted to the hospital under a Formal Voluntary can request that a 3rd copy of his/her Formal Voluntary Admission Application be sent to the person of his/her choice.

Enclosed is your copy of the application per the patient's request. If you have any questions, please don't hesitate to contact me.

Sincerely,
/s/ WILLIAM E. KIRK, M.D.
Director
York Woods Center
WEK:sh
Enc.



## EXHIBIT C

## AFFIDAVIT

I, Tom Wojciehowski, being first duly sworn, depose and say:

1. I am 24 years old; I live with my wife, Margaret Rowley, at 788 Watersedge Drive, Ann Arbor, Michigan.

2. I am educational supervisor at Family Group Homes for Youth, Inc., 2500 Packard Road, Ann Arbor, Michigan. I have taught there since November, 1973. I currently am in a master's degree program at Eastern Michigan University.

3. I was employed, first as a student teacher, then as a child care worker, at Yorkwood Center for children at Ypsilanti State Hospital, from August, 1972, through November, 1973.

4. At Yorkwood Center, I was group leader for • • •, then 9 years old, from the time he arrived at Yorkwood Center in April, 1973, until I left in November, 1973.

5. At his parents' request, I continued to work with • • • for 5-8 hours weekly, as his "big brother" in a special Yorkwood Center program.

6. I was terminated as • • • "big brother" by Harvey Day of the Yorkwood Center on May 20, 1975, after I wrote a letter to numerous people associated with • • • case at Yorkwood Center on May 6, 1975.

7. • • • has objected to being at Yorkwood Center since November, 1974. On information and belief, no one at the Center informed • • • of his right to object to his confinement at Yorkwood until he was formally voluntarily admitted on the signature of his father on February 25, 1975.

• • •, of course, had been confined for months when he was so admitted.

8. I was the person designated by • • • to receive a copy of that admission. I was not informed on February 25, 1975, that someone could object on • • • behalf to his formal voluntary admission. I did not consider myself an appropriate person to object on • • • behalf when I did learn that someone could object for him, since I was not his parent and he was not in my custody.

9. In my vocational capacity, at Mercywood Hospital, Woodruff Elementary School, and Steppingstone School, as well as Yorkwood and Family Group Homes, since January, 1971, I have worked with and observed several hundred children. I presently am working with 38 adolescents at Family Group Homes, Inc.

10. It is my opinion that • • • is not mentally ill. In my opinion, • • • is neither dangerous to himself or to others.

11. It is my opinion that in the time I have known • • •, he has never been mentally ill or dangerous to himself or to others.

12. There *is not* now and there has never been any *reason* to confine • • • to a locked hospital ward, as he has been so confined since April, 1973.

13. On information and belief, a treatment plan only recently has been requested for • • • from the Yorkwood team working with him.

14. No planning has been made for • • • in writing, except by the particular child care worker, such as myself, assigned to him. This is stated on information and belief.



15. I have no knowledge of what medication currently is being provided to • • •. In the past, he has received medication to enable him to rise during the night to go to the bathroom.

16. Although • • • has emotional problems, I do not believe he should be institutionalized as he has been. I would *recommend* placement with his parent(s), or in foster home care, in a stabilized home-type situation. Further deponent sayeth not.

/s/ TOM WOJCIEHOWSKI

County of Washtenaw
State of Michigan
Sworn to before me
this 29th day of May 1975
/s/ NANCY M. LANGELAND
NOTARY PUBLIC
Acting in Washtenaw County
My Commission Expires May 10, 1978
(Seal)

## EXHIBIT D

May 6, 1975

I have long hoped that I would not have to write this letter, but at this time, I feel I must do something. I am extremely concerned about • • • who was commited to Yorkwoods Center on April 19, 1973. My concern centers around the apathetic way in which his case has been handled. On the date above, when • • • was admitted for treatment, there were certain objectives in mind that had to be dealt with. • • • exhibited inappropriate behaviors and had problems that he had to learn to cope with.

Presently, as of this date, • • • is still in residential placement at Yorkwoods Center. That fact is quite clear, but the reason behind it is not. I have worked with • • • since his first day at Yorkwoods Center in the capacity of child care worker, Big Brother, and Advocate. My perception of • • • treatment is as follows:

1) When • • • was admitted to Yorkwoods Center, he exhibited many anxious reactions (whining, rocking back and forth, bedwetting, and withdrawal from adults and peers, amongst other things).

2) • • • parents were also having conflicts which were, many times, projected to their children. These conflicts had to be settled to create a stable home life for • • • upon his return.

3) In October, 1974, clinical rounds were held at Yorkwoods Center concerning the treatment of • • •. At this meeting, all the people who worked with • • •, his therapeutic team, were present. The purpose of the meeting was to assess the progress that • • • had made and to discuss what problems • • • still needed to work on. The findings of this meeting were:

A. • • • had worked successfully on all of his objectives and his inappropriate behavior was reduced to a bare minimum.

B. The consensus of the team was that • • • had two problems left to overcome. Those were 1) his parents were still in conflict, and 2) • • • exhibited "occasional bedwetting."

4) • • • parents have since filed for a divorce, separated, moved back together, gotten separate residences,



and have intermittently seen each other from time to time in • • • presence.

5) • • • has been permitted to see both parents at regular designated times even though his mother has stopped meeting with • • • caseworker.

6) • • • was placed temporarily in a foster home recently with many mixed messages about his family situation still unanswered.

7) • • • has voiced to me many times that he wants to leave Yorkwoods Center but is confused because he cannot accept another placement until he gets a clear message from his parents.

8) Through all of this, • • • behavior has markedly regressed since last November, at which time he felt he had completed his part of the bargain and, yet, had no place to go.

It appears to me that • • • has fulfilled his commitment and received only mixed messages and delay from all concerned. It was shown last fall that • • • could overcome the inappropriate behaviors that were the reason for his voluntary commitment. *It is also quite apparent that* • • • *parents have little investment in him, yet they cannot let go of him.* • • • entered a foster placement with his mother feeling guilty and giving him false hope of rescuing him, and his father agreeing with the placement but not giving up legal custody. Was it actually conceived that • • • would do well in this placement having to deal with those feelings as well as separation anxiety, "new" parents, sibling rivalry, and other feelings encountered in foster placement?

• • •, *being ten years old, cannot look at his situation and objectively present his defense.* Yet emotionally, he is

torn by all of these circumstances and has nothing to grasp unto except for adults that come and go on eight hour shifts and his peers on Unit 2B. This, to me, is not a very conducive environment for growth and seems to be increasingly hindering • • • from ever making a successful transition to the world outside Yorkwoods Center.

As • • • advocate I must ask the following questions:

1) Can the parents of • • • remain the legal guardians of • • • even though they cannot keep him in their household?

2) Can • • • remain incarcerated at Yorkwoods Center after he has successfully completed his treatment goals just because his parents cannot face the guilt of relinquishing custody and because • • • is diagnosed as an "occasional bedwetter"?

3) Is it no wonder why • • • behavior has regressed in the last seven months?

4) If the parents cannot decide what is best for • • •, is there not another alternative besides marking time and having • • • visit them only to return again and again to Yorkwoods Center?

I would hope for an immediate reply from someone. At this point in time, I feel many mixed emotions of sadness, anger, frustration, and confusion. Then I think of • • •, who has felt those emotions ever day for months on end and still manages to find some hope and happiness from time to time. For these reasons, I am asking for an immediate review of the treatment plan for • • •. I want to know exactly what rights, if any, • • • has concerning his present situation. I find it necessary to ask if • • • has a discharge plan! If not,



why not? If there is one, I need to know the objectives stated and when the plan will be *appropriately* implemented.

Sincerely,
/s/ Thomas W. Wojciehowski

TWW:bao
CC: Dr. Davis, MAEDC
Dr. Stehman, Director YSH
Dr. Kirk, Director YWC
Dr. Root, Psychiatrist (Therapist)
Ms. Druker, Psychologist (Family Wkr.)
Mr. Robertson, Unit Staff (Group Leader)
Mr. Pullen, Community Liaison
Ms. Berry, Teacher

2-25-75 Formal Voluntary Admission Application

5-6-75 Letter of Concern

5-12-75 Took • • • out—confronted by H. Day

5-19-75 LOA canceled by H. Day — would not speak to me at that time

5-20-75 Mts./Day, Druker, Root, Hoseinia — terminated, effective immediately

5-24-75 Rec'd letter from Dr. Kirk

## EXHIBIT E

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

| | |
|---|---|
| • • •, a minor, by his next friend, Tom Wojciehowski, Individually, and on behalf of all other minors similarly situated, Plaintiffs, | NO. JUDGE AFFIDAVIT OF THOMAS B. DARNTON |
| vs. THE DIRECTOR OF THE MICHIGAN DEPARTMENT OF MENTAL HEALTH, In his official capacity, and his successors, assignees, employees and agents; VERNON STEHMAN; WILLIAM KIRK; and HARVEY DAY, in their official capacities as employees and agents of Ypsilanti State Hospital and the Michigan Department of Mental Health, Defendants. | |

STATE OF MICHIGAN)
) SS:
COUNTY OF GENESEE)

NOW COMES THOMAS B. DARNTON, and being first duly sworn, deposes and says as follows:

1. He is an attorney duly licensed to practice law in the State of Michigan, and practices primarily in Washtenaw County, Michigan.



2. On May 30, 1975, at the request of Thomas Wojciehowski he went to the York Wood Center, located on the grounds of the Ypsilanti State Hospital, Ypsilanti, Michigan, and spoke with a minor who identified himself as • • •. • • • appeared to be a bright, active boy about 10 years old, with blue eyes and blond hair.

3. During the interview the boy on several occasions expressed his desire to leave the York Wood Center. He also stated that he was willing to have affiant try to help him.

4. Tom Wojciehowski, the adult who requested that affiant see • • •, is an adult who has acted as a "big brother" for the boy for several months.

5. Further, your affiant sayeth not.

Dated: Nov. 18, 1975

/s/ THOMAS B. DARNTON
Attorney at Law
WASHTENAW COUNTY LEGAL AID SOCIETY
130 W. Michigan Avenue
Ypsilanti, Michigan 48197
(313) 481-0500

Subscribed and sworn to before me
this 18 day of November, 1975.
/s/ MARY E. BROWN
NOTARY PUBLIC
Washtenaw County, Michigan
My Commission Expires: Nov. 29, 1978

## EXHIBIT F

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

• • •, a minor, by his next friend, Tom Wojciehowski, Individually, and on behalf of all other minors similarly situated,
Plaintiffs,

vs.

THE DIRECTOR OF THE MICHIGAN DEPARTMENT OF MENTAL HEALTH, In his official capacity, and his successors, assignees, employees and agents; VERNON STEHMAN; WILLIAM KIRK; and HARVEY DAY, in their official capacities as employees and agents of Ypsilanti State Hospital and the Michigan Department of Mental Health,
Defendants.

NO.
JUDGE
AFFIDAVIT OF ROSE MARIE ADAMO

STATE OF MICHIGAN)
) SS:
COUNTY OF GENESEE)

NOW COMES ROSE MARIE ADAMO, and being first duly sworn, deposes and says as follows:

1. That she is an attorney with Legal Services of Eastern Michigan, Flint, Michigan.

2. That on September 30, 1975, she went to York Wood Center, located on the grounds of the Ypsilanti State Hospital, Ypsilanti, Michigan, and spoke with • • •, the minor Plaintiff herein.



3. That during the interview, • • • told your affiant that he remembered very well Attorney Darnton's visit in May, 1975, and that he continued to desire to leave York Wood Center and that he wanted your affiant and Attorney Darnton to continue to try to help him.

FURTHER, your affiant sayeth not.

Dated: November 20, 1975

/s/ ROSE MARIE ADAMO
Attorney for Plaintiff
LEGAL SERVICES OF
EASTERN MICHIGAN
412 Genesee Bank Building
Flint, Michigan 48502
(313) 234-2621
(313) 481-0500

Subscribed and sworn to before
me this 20 day of October, 1975.
/s/ JOE A. BENAVIDEZ
Notary Public, Genesee County, Michigan
My Commission Expires: April 10, 1976

IN THE UNITED STATES DISTRICT COURT FOR
THE EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

• • •

TOM WOJCIEHOWSKI, Next Friend
of JOHN DOE, a Minor, on behalf
of JOHN DOE and all others
similarly situated,

Plaintiff,

-vs- Case No. 75-72318

THE DIRECTOR OF THE MICHIGAN
DEPARTMENT OF MENTAL HEALTH,
et al,

Defendants.

ANSWER

Intervenors, Mr. and Mrs. John Doe, Sr., are the parents of John Doe, Jr., the nominal Plaintiff in the above-captioned matter. By their attorneys, MILLER, KLIMIST, COHEN, MARTENS & SUGERMAN, P.C., and in answer to the Complaint filed herein, Intervenors state as follows:

1. Answering Paragraph 1, Intervenors admit that the nominal Plaintiff, John Doe, Jr., is a minor and that the Formal Voluntary Admission provisions of Michigan's Mental Health Code (MCLA 330.1415-1420) took effect approximately November 6, 1974. Intervenors deny that their son, John Doe, Jr., is the "Plaintiff." Intervenors deny that John Doe, Jr., "brings this action," that he "challenges the constitutionality" of the aforementioned statutory provisions, or that he "seeks to have" said statutory provisions "enjoined and declared unconstitutional."



Intervenors do not respond to the remainder of Paragraph 1, which consists of legal theories, arguments and conclusions which are erroneous and for which no answer is required.

Affirmatively, Intervenors assert that, as the natural parents and guardians of John Doe, Jr. they are entitled and duty-bound to provide for his care and custody. This lawsuit was brought by Tom Wojciehowski and his attorneys, Rose Marie Adamo, Thomas Darnton and Gabe Kaimowitz, because they (Mr. Wojciehowski and his attorneys) "seek to have" the aforementioned statutory provisions "enjoined and declared unconstitutional." To achieve that objective, the above individuals, who are callously indifferent to the needs and best interest of John Doe, Jr., merely affixed John Doe, Jr.'s name to the Complaint herein. This was done without the authorization, permission, consent or even knowledge of Intervenors, who first heard of this lawsuit on a radio broadcast.

2. Answering Paragraph 2, that paragraph states a legal theory which is erroneous and for which no answer is required. Affirmatively, Intervenors assert that, to the extent that this suit challenges the confinement of John Doe, Jr. and other individuals, the exclusive remedy is a writ of habeas corpus. Therefore ,this Court lacks jurisdiction over the subject matter of the Complaint because this is not an appropriate cause of action pursuant to 42 USC §1983, and the nominal Plaintiff has failed to exhaust his available state remedies or otherwise satisfy the jurisdictional requirements of 28 USC §2254.

The "real" Plaintiffs herein are Mr. Wojciehowski, Ms. Adamo, and Messrs. Darnton and Kaimowitz. None of the aforenamed individuals possesses either the authorization or standing necessary to bring this lawsuit.

3. Answering Paragraph 3, Intervenors deny the allegations of jurisdiction contained therein for the reasons set forth in their answer to Paragraph 2.

4. Answering Paragraph 4, Intervenors deny that this is a proper cause for determination by a three-judge court pursuant to 28 USC §§ 2281 and 2284 for the reasons set forth in their answer to Paragraphs 2 and 3. The remainder of that paragraph consists of legal theories and conclusions which are erroneous and for which no answer is required, and of the stated intentions of Mr. Wojciehowski and his attorneys, which are not attributable to John Doe, Jr. or the members of the putative class, and for which no answer is required.

5. Answering Paragraph 5, Intervenors admit that their son, John Doe, Jr., is eleven years old and a citizen of the United States. Intervenors deny that their son is or ever has been "incarcerated" which allegation should be striken as false and misleading. Affirmatively, Intervenors assert that their son was admitted to the York Woods Center for Children to receive the medical care and treatment necessitated by his illness. John Doe, Jr., suffers severe mental and emotional illness. From approximately age four and thereafter, John Doe, Jr., has exhibited the following:

— Encephalopathy (brain damage);
— Many of the features of an autistic child;
— Borderline retarded intellectual potential and functioning;
— Possible arrested hydrocephaly;
— Psychotic-like behavior;
— A borderline psychotic personality disorder;
— Deep, seething rage;
— An inability to distinguish fantasy from reality;



— Latent schizophrenia and possible childhood schizophrenia;
— An obsessive preoccupation with death, blood and gore;
— Bizarre and widely fluctuating relationships with people in his life;
— Compulsive, violent, assaultive behavior;
— Severe anxiety and withdrawal;
— Echolalia with bizarre and totally inappropriate verbal responses;
— Enuresis and encopresis

Intervenors love their son. As parents and natural guardians of John Doe, Jr., Intervenors have a moral and legal obligation, as well as a legal right, to provide for his care and custody. That obligation includes a duty to provide for their son's medical needs, including treatment and care for his mental and emotional illness. In furtherance and fulfillment of that parental responsibility, Intervenors admitted their son to York Woods in order to secure medical treatment and care for his severe mental and emotional illness.

6. Answering Paragraph 6, Intervenors admit that Mr. Wojciehowski worked at York Woods Center, that Mr. Wojciehowski became acquainted with John Doe, Jr., while at York Woods, and that Mr. Wojciehowski continued as a "Big Brother" to John Doe, Jr. from approximately December of 1973 until May of 1975. Intervenors deny that Mr. Wojciehowski is suitable or competent to be John Doe, Jr.'s Next Friend. Intervenors are without knowledge or information sufficient to form a belief as to the truth or falsity of the remaining allegations in Paragraph 6, and leave Mr. Wojciehowski and his attorneys to their proofs.

Affirmatively, Intervenors assert that they are not in-

competent, unsuitable or neglectful parents and that they are neither assumed nor actual adversaries of their son. Intervenors oppose the initiation and continuation of this suit and oppose the appointment of any Next Friend, and particularly Mr. Wojciehowski, for the purposes of maintaining this suit. Further, Intervenors allege that this Court lacks authority to appoint a Next Friend for the purpose of maintaining this lawsuit absent a prior showing that Intervenors are unsuitable parents and actual adversaries of their son.

7. Answering Paragraph 7, Intervenors admit that the Director of the Michigan Department of Mental Health is a Defendant herein and that said position is currently occupied by Donald C. Smith. Intervenors are without knowledge or information sufficient to form a belief as to the truth or falsity of the remaining allegations contained therein, and leave Mr. Wojciehowski and his attorneys to their proofs.

8. Answering Paragraph 8, Intervenors admit that the Director of Ypsilanti State Hospital is a Defendant herein and that said position is currently occupied by Vernon Stahman. Intervenors are without knowledge or information sufficient to form a belief as to the truth or falsity of the remaining allegations in Paragraph 8, and leave Mr. Wojciehowski and his attorneys to their proofs.

9. Answering Paragraph 9, Intervenors admit that the Director of York Woods is a Defendant herein and that said position is currently occupied by William Kirk. Intervenors are without knowledge or information sufficient to form a belief as to the truth of falsity of the remaining allegations in Paragraph 9, and leave Mr. Wojciehowski and his attorneys to their proofs.



10. Answering Paragraph 10, Intervenors admit that Harvey Day works at York Woods. Intervenors are without knowledge or information sufficient to form a belief as to the truth or falsity of the remaining allegations contained therein, and leave Mr. Wojciehowski and his attorneys to their proofs.

11. Answering Paragraph 11, Intervenors deny that John Doe, Jr., brings this action on behalf of himself or any other persons. This action is brought by Mr. Wojciehowski and his lawyers who are callously indifferent to the best interests of John Doe, Jr. and the other members of the putative class. Further, Mr. Wojciehowski and his attorneys filed the Complaint herein one month after the Honorable James Harvey of the United States District for the Eastern District of Michigan ruled that they should not involve "their client," John Doe, Jr., in a complex, federal class action because that would be harmful to John Doe, Jr.'s best interests. See Opinion denying Petition to Intervene, *Deborah White* v *The Director of the Michigan Department of Mental Health, et al*, Case No. 75-10022.

12. Answering Paragraph 12, Intervenors deny the allegations contained therein.

13. Answering Paragraph 13, Intervenors deny the allegations contained therein.

14. Answering Paragraph 14, Intervenors deny the allegations contained therein.

15. Answering Paragraph 15, Intervenors deny the allegations contained therein.

16. Answering Paragraph 16, Intervenors deny the allegations contained therein. John Doe, Jr. is a purely nominal Plaintiff who has been virtually abducted by the

real Plaintiffs, Mr. Wojciehowski and his attorneys, who are callously indifferent to the needs and interests of John Doe, Jr. and the putative class.

Mr. Wojciehowski's attorneys have already represented to this Court that from their point of view (i.e. the point of view of Mr. Wojciehowski and his attorneys) whether the nominal Plaintiff needs in-patient medical care, whether the nominal Plaintiff would be traumatized by an adversary, pre-admission judicial hearing, or whether the prospect of such traumatization would serve to effectively deny the nominal Plaintiff necessary medical care, are matters of total irrelevance.

Further, the claims asserted in the Complaint are directly contrary to the best interests of the nominal Plaintiff and the putative class. If accepted, said claims would subject mentally ill children and their families to stigmatizing public records and judicial findings of insanity, and to traumatic, adversary judicial proceedings which would compound their mental and emotional problems. Additionally, said claims would deny needed medical treatment to mentally ill children. Finally, said claims would undermine the principle of parental responsibility and accountability which is fundamental to the protection of all children, including children who suffer mental or physical illness, in a democracy such as ours. "Many children [would] see the [nominal] Plaintiff's victory, not as a blessing, but as a curse. One can readily imagine some children saying to the [nominal] Plaintiff, 'if you want to help us, drop your lawsuit.'" See Opinion of Honorable Victor J. Baum in *Clarice Jobes, et al* v *The Michigan Department of Mental Health, et al*, Wayne County Circuit Court, Civil Case No. 74-004-130-DC.



17. Answering Paragraph 17, Intervenors deny the allegations contained therein.

18. Answering Paragraph 18, Intervenors deny the allegations contained therein.

19. Answering Paragraph 19, Intervenors admit the allegation contained therein. Further, Intervenors assert that they admitted their son to in-patient care at York Woods Center because he is severely mentally and emotionally ill as described in the Answer to Paragraph 5. Intervenors reach this decision after consultation with, and in accordance with the advice of, a great many psychiatrists, physicians, psychologists, and other professional personnel trained in the diagnosis and treatment of mental illness.

20. Answering Paragraph 20, Intervenors admit that no court hearing was held prior to John Doe, Jr.'s voluntary admission to York Woods Center. Further, Intervenors assert that an adversary, pre-admission judicial proceedings would have compounded their son's mental and emotional illness, and would have subjected their son and his family to permanent and irreparable stigmatization and traumatization.

21. Answering Paragraph 21, Intervenors deny the allegations contained therein. Further, Intervenors assert that on February 25, 1975 and subsequently, John Doe, Jr. was advised of his right to object to his hospitalization at York Woods Center and did not object.

22. Answering Paragraph 22, Intervenors admit that on or about February 25, 1975 Mr. Wojciehowski received a copy of Exhibits A and B.

23. Answering Paragraph 23, Intervenors deny the alle-

gations contained therein. Mr. Wojciehowski received a copy of John Doe, Jr.'s formal voluntary admission application. That document sets forth in bold type all the necessary information as to who may object and how. As the individual designated to receive said document, Mr. Wojciehowski had a prima facie right to object to the nominal Plaintiff's admission. Further, the cover letter accompanying said application expressly advised Mr. Wojciehowski to direct any questions he had to the Director of York Woods. On information and belief, Mr. Wojciehowski did not ask the Director of York Woods if he could object. Further, since approximately June of 1975 (six months prior to this lawsuit) Mr. Wojciehowski has had the assistance and advice of his attorneys in this lawsuit. Finally, in September of 1975 the Honorable James Harvey specifically advised Mr. Wojciehowski and his attorneys that an objection to the admission of the nominal Plaintiff to York Woods could be filed in probate court.

24. Answering Paragraph 24, on information and belief Intervenors admit that Mr. Wojciehowski wrote the letter referred to as Exhibit "D." Intervenors deny the remaining allegations contained therein.

Affirmatively, Intervenors assert that Mr. Wojciehowski is not qualified to make any diagnosis as to the mental and emotional illness of the nominal Plaintiff. John Doe, Jr. is severely mentally and emotionally ill and very dangerous to himself and others for the reasons set forth in the answer to Paragraph 5. In December of 1975, the nominal Plaintiff swallowed a great number of pills which he had obtained surreptitiously and was spared serious harm only because the pills were harmless. In February of 1975, an attempt was made to temporarily place the nominal Plaintiff with a foster family. The prospective foster parents re-



turned the nominal Plaintiff to York Woods within twenty-four hours because he had injured their two year old infant by physically assaulting the infant and attempting to set the infant on fire.

25. Answering Paragraph 25, Intervenors admit that Mr. Wojciehowski was terminated as a big brother on about May 20, 1975. Affirmatively, Intervenors assert that Mr. Wojciehowski was terminated because he disclosed totally false, malicious, stigmatizing and confidential information concerning John Doe, Jr. and his family to persons outside the Department of Mental Health and in violation of MCLA 330.1746. Further, Mr. Wojciehowski initiated this suit for the purpose of retaliating against York Woods for his termination.

26-29. Answering Paragraphs 26 through 29, Intervenors admit that the nominal Plaintiff was visited by attorneys Darnton and Adamo. Intervenors deny the remaining allegations contained therein.

Affirmatively, on information and belief, Intervenors assert that during said visits, Mr. Darnton and Ms. Adamo exercised undue influence on John Doe, Jr. in an attempt to persuade him to serve as their Plaintiff; that they misled, harassed and badgered him; that they told him to stop attending bi-weekly therapy sessions with a psychiatrist; and that, despite all the foregoing, John Doe, Jr. never expressed a clear desire to leave York Woods and never expressed any desire to start this suit. John Doe, Jr. reacted to the foregoing "visits" by exhibiting an increase and an intensification of many of the indicia of his mental illness, such as seething rage, bizarre, violent and destructive behavior, echolalia, and severe anxiety and withdrawal.

30. Answering Paragraph 30, Intervenors admit that

John Doe, Jr. remains as an in-patient at York Woods and that he has not received a hearing before any Michigan court or tribunal. Intervenors deny that John Doe, Jr. has objected to his hospitalization. Intervenors deny that John Doe, Jr. has ever been "incarcerated." Intervenors continue to spend a great deal of time with their son during his hospitalization. They visit with their son at York Woods on a regular and frequent basis. John Doe, Jr. leaves York Woods to spend time with his parents on a regular and frequent basis of at least one day each week and often more. Further, it is Intervenors' hope and expectation that their son's mental illness will be sufficiently alleviated by the Summer or Fall of 1976 so that his in-patient hospitalization can be concluded.

Further, Intervenors assert that the nominal Plaintiff has not received a hearing before a Michigan court because Mr. Wojciehowski has refused to utilize any of the expeditious remedies available in Michigan courts despite Judge Harvey's Opinion that they should do so to serve "their client's" best interests.

31. Answering Paragraph 31, Intervenors deny the allegations contained therein.

32. Answering Paragraph 32, Intervenors deny the allegations contained therein. In support of their denial, Intervenors assert that the nominal Plaintiff and the putative class have a choice of expeditious and adequate remedies in Michigan courts, including an objection filed pursuant to MCLA 330.1415-1420; a writ of habeas corpus; or neglect proceedings in probate court.

Further, John Doe, Jr. and the members of the putative class are suffering no harm whatsoever as the result of the operation of the Michigan Mental Health Code because



said statutory provisions enable them to obtain treatment for their medical problems without the stigmatization and traumatization of public records and adversary judicial proceedings. To the contrary, it is the conduct of Mr. Wojciehowski and his attorneys and the initiation and continuation of this lawsuit which has and continues to cause John Doe, Jr. irreparable harm.

Hospitalization and treatment at York Woods significantly alleviated John Doe, Jr.'s mental and emotional problems. By the initiation of this unauthorized lawsuit, Mr. Wojciehowski and his attorneys have subjected the entire Doe family to the stress of adversary litigation (where no adversary relationship exists) and permanent public stigmatization. Moreover, as a result of this lawsuit and the aforementioned visits by Mr. Wojciehowski's attorneys, progress in the treatment of John Doe, Jr.'s mental problems has stopped and, in fact, John Doe, Jr. has regressed.

The irreparable harm and injury which Mr. Wojciehowski and his attorneys have done to "their client," John Doe, Jr., by this lawsuit, is the very "relief" which they insist upon for every member of the putative class in the form of a mandatory, public, adversary judicial proceeding prior to hospitalization for treatment of mental disease. It is the "relief" which Mr. Wojciehowski and his attorneys seek which would cause irreparable harm to John Doe, Jr. and the members of the putative class. Such harm, however, is admittedly irrelevant to Mr. Wojciehowski and his attorneys.

33. Answering Paragraph 33, Intervenors reallege their answers to Paragraph 1 through 32 as set forth above.

34. Answering Paragraph 34, Intervenors deny the al-

legations contained therein. John Doe, Jr. has never been incarcerated. Joe Doe, Jr. has not been "subjected to forced chemotherapy." On the advice and judgment of his parents and physicians, he has received medication to relieve physical illnesses and enuresis. John Doe, Jr. was never "stigmatized" by hospital records until this lawsuit. He has now, however, been so stigmatized due to the release of confidential and misleading information by Mr. Wojciehowski and his attorneys. John Doe, Jr. has never been transferred between hospitals.

35. Answering Paragraph 35 and subparagraphs (a) and (b) thereof, Intervenors admit that John Doe, Jr. did not receive an adversary and traumatic judicial hearing prior to his hospitalization for treatment of mental illness. Intervenors deny that such a hearing is constitutionally mandated or in the best interest of John Doe, Jr. and the putative class. Intervenors deny each and every other allegation contained in Paragraph 35 and subparagraphs (a) and (b) thereof.

36. Answering Paragraph 36, Intervenors deny the allegations contained therein.

37. Answering Paragraph 37 and subparagraphs (a), (b), (c), (d) and (e) thereof, Intervenors deny the allegations contained therein.

WHEREFORE, Intervenors pray that the Complaint be dismissed in its entirety and that Intervenors be granted such actual costs and attorneys fees as the Court may deem appropriate.



## AFFIRMATIVE DEFENSES

NOW COME INTERVENORS, by their attorneys, MILLER, KLIMIST, COHEN, MARTENS & SUGERMAN, P.C., and for their Affirmative Defenses state as follows:

1. This is not a true class action.

2. This action is unauthorized.

3. John Doe, Jr. is a purely nominal and improper Plaintiff. Mr. Wojciehowski and his attorneys are the real Plaintiffs herein, and they lack standing to bring this action.

4. The Court lacks jurisdiction over the subject matter of this action.

This action, at bottom, is intended and has the effect of divesting Intervenors of their obligation and right to the custody and control of their child, John Doe, Jr. To entertain this action, absent a prior showing of parental unsuitability or neglect, is an unconstitutional infringement without due process of law on John Doe, Jr.'s right to the nurturing care and custody of his parents, and the right and duty of his parents to provide such care and custody. Further, matters of parental unsuitability and neglect lie within the primary and exclusive competence of state courts.

5. The Court lacks jurisdiction over the subject matter of this action because a writ of habeas corpus is the exclusive remedy for challenging the confinement of individuals in a mental institution.

6. Plaintiffs have failed to exhaust available state remedies.

7. Parents and guardians are responsible for the welfare of their children. They are the persons held accountable, both civilly and criminally, to see to the physical, medical and emotional needs of their children. The responsibilities imposed upon parents and guardians include the corollary duty to secure appropriate medical treatment, whether physical or mental, as required by the facts or circumstances. Any rule of law that divests children of the protection and accountability of parents and guardians leaves children without the safeguards and protections their dependent status requires. Such a rule of law would be subversive of the family as a unit and hence of the social order which is the legally recognized basis of all family law.

8. Adults are conceded the right by the Plaintiffs to voluntary medical treatment for emotional problems without the necessity of being stigmatized as insane through an involuntary proceeding. Plaintiffs' insistence that children, in order to secure medical treatment for emotional ills must first be declared insane, sets up an arbitrary and unreasonable classification discriminating against the just rights of children and their parents and guardians in violation of the Federal and Michigan Constitutions.

9. Public health facilities are designed primarily to serve the needs of persons whose financial conditions prevent the use of private facilities. Children with emotional ills may secure, through their parents and guardians, private help without prior adjudications of insanity. Plaintiff's adjudication of insanity sets up an arbitrary and unreasonable classification discriminating against those whose financial status requires them to use public facilities in violation of the Federal and Michigan Constitutions.



WHEREFORE, Intervenors pray that the Complaint be dismissed in its entirety and that Intervenors be granted such actual costs and attorneys fees as the Court may deem appropriate.

MILLER, KLIMIST, COHEN, MARTENS
& SUGERMAN, P.C.

By.....
BRUCE A. MILLER

-and-

By.....
SAMUEL C. McKNIGHT
Attorneys for Intervenors
2460 First National Building
Detroit, Michigan 48226
965-7540

DATED: APRIL 22, 1976.

STATE OF MICHIGAN)
) SS:
COUNTY OF WAYNE )

I, Ralph D. Rabinovitch, M.D., after first being duly sworn, upon my oath affirm and say that:

I am a graduate in medicine, McGill University, Montreal, Canada. I received my psychiatric training at Toronto University and New York University. I served as a Research Fellow in Child Psychiatry at Bellevue Hospital. From 1949 to 1956, I was Chief of Children's Psychiatric Service, and Associate Professor of Psychiatry at the University of Michigan. In 1956, I assumed the position of Director of Hawthorn Center, an inpatient, outpatient and day care facility for treatment, training and research in

child psychiatry under the Department of Mental Health, State of Michigan. Hawthorn Center is now one of the largest state-sponsored mental health centers for children and adolescents in the country. Since 1971, I have been Director of Clinical Research at Hawthorn Center.

Over a period of many years, I have served as consultant to numerous social agencies and schools. One of my major concerns is the integration of child psychiatry, social work and education on a broad community level. I have written on a wide range of topics relating to the psychopathology of childhood and psychotherapy, including childhood schizophrenia, juvenile delinquency, residential treatment, reading and language disabilities and, most recently, drug abuse and its psychological and social implications.

Attached to this Affidavit are case summaries, prepared under my direction and supervision, describing the inpatient population at Hawthorn Center on May 1, 1974. These studies are, to the best of my knowledge, true and accurate except to the extent necessary to preserve anonymity and confidentiality. Also, these case summaries are representative of the present inpatient population at Hawthorn Center.

The issues involved in psychiatric inpatient care for children are complex. As so often happens in abstract discussions of complex social issues, much current rhetoric concerning psychiatric hospital care for children has a great tendency to stray from fact. Oversimplification and overgeneralization cloud the basic issues.

No one likes the idea of psychiatric hospitalization for children. The concept tends to evoke fears and anxieties in many concerned citizens, and, because children are involved, these emotions are particularly exploitable.



Often two distinct and separate issues are confused — the right to treatment and the quality of treatment. The community, through its governmental enabling and licensing agencies, and through its courts, has the right and duty to demand the highest standards of care for its disturbed children.

The solution to substandard treatment is not the abolition of all treatment opportunities but the amelioration or replacement of substandard programs. The routine, subtle use of such opprobrious invectives as "incarceration', 'guinea pig experimentation', 'drugging' in references to all children's psychiatric hospitals is as inflamatory as it is unreasonable. There are good children's psychiatric hospitals and bad children's psychiatric hospitals; throughout this Affidavit, I am referring to the good ones.

In the practice of child psychiatry no situation requires more care and sensitivity than the planning of hospitalization for a child. Two broad issues are involved — clinical considerations and the reactions of child and family.

1. *Clinical Considerations.*

Currently the assumption is often expressed that admission procedures are cursory, that parents can simply deposit children and leave. Nothing could be farther from the truth. The usual minimal admission procedure is as follows: first, admission is recommended by a worker in the community who knows the child and family well — the pediatrician, family physician, community mental health clinic worker, school social worker or psychologist, judge or court worker. Next, the child is evaluated in the hospital outpatient clinic with the most experienced professional staff involved. Then full consideration is given the possibilities for non-hospital treatment alternatives.

For the large majority of children for whom hospitalization is recommended, numerous treatment alternatives have already been tried in the community. The case summaries of the inpatients at Hawthorn Center demonstrate that nearly every parent has tried some form of alternative treatment before agreeing to hospitalization.

These case summaries also illustrate the wide range of disturbances the patients suffer. Each child requires detailed study, no less than is appropriate in any medical clinic. Too often it is forgotten that child psychiatry is a branch of pediatrics, and not an isolated or independent discipline. Childhood schizophrenia, brain injury, epilepsy, anorexia and phobic states are no less medical than chronic arthritis, brain tumor, cardiac disease, endocrine imbalance or asthma.

Despite years of public education, it is still often difficult to convince parents and children of these realities and of the fact that there should be no special stigma attached to mental illness or emotional disturbance.

2. *Reactions of Child and Family.*

Any hospitalization of a child is rarely easy for child or parents; psychiatric hospitalization is particularly difficult. Acceptance of the recommendation for admission often leads to strong resistance. In many cases it is more difficult for the parents than for the child. There are many reasons for this. The parents' compassion for the child and his plight may be overwhelming. The concept of hospitalization may suggest dire portent. Strong feelings of inadequacy or guilt may be activated. Despite the fact that the need for hospitalization is clearly appreciated, the parent may find it impossible to follow through, leading to postponements that further jeopardize the child's future.



The following two case studies are typical:

*GEORGE*

George, an 11-year-old boy, was referred to Hawthorn Center for admission by a school social worker because of long-term inability to attend school dating back to his early school days. In addition to the school refusal problem George had developed phobic symptoms, being unable to leave home even for brief shopping trips. George simply sat at home day and night. He also had discontinued all contact with peers. The school's special services had worked very hard to help George and he had received eighteen months of psychotherapy in the community. Both the school and the referring community clinic had strongly recommended inpatient treatment but the parents had been unable to accept the recommendation.

Again inpatient treatment was recommended by the hospital staff and again the parents refused. Another three-month trial of outpatient treatment proved fruitless and George remained immobilized at home. After a further delay the parents asked if they might talk with the parents of other children who had been admitted to the hospital with similar problems. The group was helpful and finally George was admitted, his parents still extremely threatened and anxious.

In the hospital George responded rapidly to the milieu, the school program and psychotherapy. He was able to return home and to the public school in three months and has continued to do well.

*JOYCE*

At age 7 years Joyce was referred to the psychiatric hospital because she had never talked in school. The parents

reported that she had never uttered a word to anyone outside the immediate family. The diagnosis of elective mutism was made and outpatient treatment was begun. Joyce did not respond and a brief period of inpatient care was felt necessary to help reverse the pattern of mutism. Joyce was willing to enter the inpatient program but the parents' anxiety did not permit them to follow through. They were encouraged to keep in touch with the hospital and the door was left open for Joyce's admission at any time.

The hospital did not hear from the family for the next four years, when Joyce was re-referred. She had remained mute throughout this entire period and her social adjustment had deteriorated seriously. She was withdrawn and depressed. Again inpatient treatment was strongly recommended and rejected by the parents. They simply could not bring themselves to the point of separation and feared for Joyce's safety in the hospital. Again the door was left open and nine months later the parents called to ask if Joyce could be admitted. She remained in hospital for five months and made slow, steady improvement. She talked first to her therapist, then to her classroom teacher, to a nurse, to several child care workers, and finally to other students. Her anxiety and depression lifted and she returned to home and public school where she is adjusting well, talking comfortably and enjoying life.

Casebooks are filled with examples of the anxiety that the need for a child's psychiatric hospitalization engenders in parents, to the point that many parents cannot bring themselves to acquiescence even when they know that hospitalization is imperative. If confronted with the prospect of a coerced adversary court hearing, many parents would



simply be unable to undergo the trauma. George and Joyce are but two common examples.

In the above two cases hospitalization was finally made possible and the outcome was positive. Unfortunately, not all cases end this way. In many, hospitalization continues to be resisted with progressive deterioration in the child's adjustment and in some cases, ultimate disaster.

*DOLORES*

At age 14 Dolores was referred by the school and the family service agency for consideration of admission to hospital because of her aggressive, threatening behavior at home and her extreme unhappiness and expressed anger at school. Dolores was particularly negative towards her sister, Tina, two years younger, whom she viewed as the favored child in the family.

Diagnostic studies in the hospital outpatient clinic indicated that Dolores was tormented by feelings of self-deprecation and jealousy and she was having great difficulty controlling her aggressive impulses.

Hospitalization was recommended and every effort was made to persuade the parents to agree, but they felt much threatened by the prospect of separation and Dolores remained at home. At the time of the outpatient evaluation there was no clear-cut indication for involuntary commitment.

Ten months later Dolores murdered Tina in an episode of rage, brought on by a new dress than Tina was wearing.

*BILL*

From age 13 years, Bill had been involved in drug abuse, using many street drugs, often in large quantity. At age 16,

after a serious overdose, he was referred by the family doctor for hospitalization.

Diagnostic studies in the hospital outpatient clinic revealed a very bright, sensitive, troubled boy who had established a self-image, life style and subgroup peer identification from which he could not escape. Immediate hospitalization was indicated and strongly recommended.

Bill was more than willing to accept inpatient care, but he was persuaded by a community drug abuse clinic and an agency lawyer to reject the recommendation. His parents could not prevail and Bill remained on the streets.

Four months later Bill died in a dope house from an overdose. Several times in the previous months, desperate for help, Bill had called the doctor with whom he had talked at the hospital but the drug abuse clinic and the lawyer continued to dissuade him from accepting "incarceration".

These tragedies are difficult enough for families to bear without the added burden of undue blame or assumed inevitable negative parent motivation. The assumption that most parents are the enemies of their troubled children is pure myth. Clinical reality, in fact, tells us clearly that in most families, when the necessity for child's psychiatric hospitalization becomes clear, there are appropriate mutual human responses of compassion. The large majority of parents and children remain humane, decent people who respond appropriately at time of family crisis.

Coerced adversary hearings will have a particularly negative effect upon children of poverty families. Professional literature documents the fact that low income families have traditionally been reluctant to use mental health services. The real battle in this area has been to design



practical services that meet needs, and to motivate families to use the services that are available. Coerced adversary court hearings will simply prove an insurmountable barrier. It is often difficult for low income families to discuss domestic problems in the clinic setting. It will be all the more so in the court setting. It is unrealistic to expect any parent to willingly testify to personal family problems for a public record in a court of law.

In the context of coerced adversary proceedings, psychiatric disturbance in children becomes no longer a medical concern but a legal one. Responsibility for the health of children with a wide range of medical-psychiatric problems will be removed from medical and placed under legal responsibility. What criteria will the Court use? If the only method of hospitalization for a child is that presently used for involuntary commitment (homicide or suicide threat), over 90% of patients will be denied the hospital care they need. The attached case summaries demonstrate this point (see cases 5, 12, 25, 26, 37, 48, 59, 85, 91, 97, 139).

If the need for hospitalization itself is used, a very serious problem is presented. The Court will have to develop criteria to determine that need. How much anxiety will the Court require before ordering hospitalization? What weight loss will the Court require before adolescents with anorexia nervosa are permitted to receive hospital care? How severe must a child's rage reaction be before the Court will order his hospitalization for psychomotor epilepsy? How discouraged, immobilized and negative about himself must a non-suicidal, depressed child be before the Court will sanction his admission to hospital for treatment?

These are not irrelevant or rhetorical questions. They strike at the heart of the issue before us and cannot be ignored. In my opinion, to redefine emotional disturbance

in children to conform to a judicial rather than a medical standard is regressive, anachronistic and dangerous.

/s/ RALPH D. RABINOVITCH, M.D.

Subscribed and sworn to before me on this 7th day of June, 1976.

/s/ CELIA T. BUCHINSKI
Notary Public, Wayne County, MI
My commission expires: October 8, 1978

No. 1

*Presenting Problem:* Bizarre behavior including unprovoked screaming spells, panic attacks and aggressive acting out; very limited and idiosyncratic speech and language; severe asocial withdrawal.

*Diagnosis:* Childhood Schizophrenia.

*Previous Interventions:* School special services. Psychotherapy — out-patient clinic, community hospital. In-patient care — public psychiatric hospital.

No. 2

*Presenting Problem:* Bizarre behavior, two-months duration; auditory hallucinations and delusions; delinquent acting-out in the community including breaking and entering; preoccupation with knives and frequent "play with knives".

*Diagnosis:* Schizophrenia of adolescence.

*Previous Interventions:* Psychiatric study hospital outpatient clinic. Juvenile Court. Juvenile detention facility. Private psychiatric hospital — in-patient care. Committed as mentally ill to Hawthorn Center through Probate Court.

No. 3

*Presenting Problem:* School refusal — refractory to community efforts; severe academic learning impairments.



*Diagnosis:* Dyslexia, severe. Psychoneurosis. Neglected child.

*Previous Interventions:* School special services.

No. 4

*Presenting Problem:* Toxic states from drug and alcohol overdoses in community; chronic stealing and other acting-out behavior; fire-setting.

*Diagnosis:* Psychoneurosis

*Previous Interventions:* Psychotherapy in out-patient clinic, community hospital. In-patient hospital care following emergency admission for drug overdose — community hospital. In-patient care — private psychiatric hospital in community.

No. 5

*Presenting Problem:* Bizarre behavior pattern since infancy; failure to develop speech and language for communication; accident-proneness despite excellent home care; panic attacks with minimal provocation.

*Diagnosis:* Childhood Schizophrenia.

*Previous Interventions:* Speech and hearing studies — community clinic. Family therapy — community mental health clinic. Psychiatric consultation — specialized clinic. Psychiatric day care in community mental health program.

No. 6

*Presenting Problem:* Bizarre behavior with many delusions, inappropriate affect and apparent disorientation—acute onset.

*Diagnosis:* Schizophrenia of adolescence.

*Previous Interventions:* In-patient care—public psychiatric hospital for acute psychosis with transfer to H.C.

No. 7

*Presenting Problem:* Sadistic aggression against younger children and animals; fire setting including gas tank of family car; inability to attend public school.

*Diagnosis:* Borderline mental retardation. Chronic deprivation and neglect.

*Previous Interventions:* School special services. Special education classroom in public school. Diagnostic studies—psychiatric hospital in community. Hospitalization—psychiatric hospital in community. Placements—two residential group care programs—excluded from both because of behavior. Committed as mentally ill to Hawthorn Center through Probate Court.

No. 8

*Presenting Problem:* Impulsive acting-out behavior; excluded from school because of threats with knives; very unhappy child with negative self image.

*Diagnosis:* Relatively affectionless personality.

*Previous Interventions:* School special services. Family therapy — private practitioners. Special education classroom in public school. Juvenile court and detention facility. Hospitalizations—private and public hospitals.

No. 9

*Presenting Problem:* Marked sexual preoccupations and sexual acting-out in community; unresponsive to efforts of protective services in community.

*Diagnosis: Psychoneurosis.* Chronic deprivation and neglect.

*Previous Interventions:* School special services. Special education classroom in public school. Protective services—many community agencies.



No. 10

*Presenting Problem:* Fire setting; grave danger to life of family members and neighbors; life-long pattern of developmental and adjustment problems.

*Diagnosis:* Schizophrenia.

*Previous Interventions:* Pediatric efforts from earliest years. School special services. Family therapy—out-patient clinic community hospital.

No. 11

*Presenting Problem:* Uncontrolled impulsive behavior at school and in community; primitive behavior such as persistent urinating on other children.

*Diagnosis:* Encephalopathy; deprivation and neglect.

*Previous Interventions:* In-patient care program for retarded children. Hospitalization—long-term treatment in psychiatric hospital. Placement — residential group care program—excluded because of behavior. Phychiatric day care in mental health program.

*Diagnosis:* Schizophrenia.

No. 12

*Presenting Problem:* Increasing social withdrawal and inertia; bizarre preoccupations; alternating excitement and depression, requiring emergency admission.

*Diagnosis:* Schizophrenia of adolescence.

*Previous Interventions:* School special services.

No. 13

*Presenting Problem:* Suicide attempts requiring hospitalization in community; sadistic physical attacks on children and adults.

*Diagnosis:* Schizophrenia.

*Previous Interventions:* School special services. Family

therapy. Several community mental health clinics. Placement in two residential group care programs—excluded from both because of behavior. Juvenile court and detention facility. Hospitalization—private psychiatric hospital in community.

No. 14

*Presenting Problem:* Very poor adjustment at home, at school and in community; repeated stealing and vandalism in community; strong feelings of rejection with reactive counter-aggression.

*Diagnosis:* Psychoneurosis; chronic deprivation and neglect.

*Previous Interventions:* Family therapy. Community health clinic. Special education class in public school. Placement in residential group care program in community—excluded because of behavior.

No. 15

*Presenting Problem:* Marked unhappiness with feelings of isolation; negative self percept and inability to relate with peers; reactive behavior problems.

*Diagnosis:* Psychoneurosis with depression.

*Previous Interventions:* School special services.

No. 16

*Presenting Problem:* Encopresis—intractible.

*Diagnosis:* Psychoneurosis.

*Previous Interventions:* School special services—three school systems. Placement in residential group care program in community—excluded because of problem.

No. 17

*Presenting Problem:* Sadistic sexual attacks on younger



children; severely destructive temper outbursts; unable to attend school.

*Diagnosis:* Encephalopathy with impulse disorder.

*Previous Interventions:* School special services. Day care psychiatric program in the community—excluded because of behavior. Juvenile court interventions. Hospitalization—private psychiatric hospital in community.

No. 18

*Presenting Problem:* Very poor social skills and negative self percept; marked academic underachievement, reactive; chronic behavior problem at home, in school and in community.

*Diagnosis:* Psychoneurosis with depression.

*Previous Interventions:* School special services.

No. 19

*Presenting Problem:* Repeated sexual assaults on children in the community.

*Diagnosis:* Relatively affectionless personality. Dyslexia.

*Previous Interventions:* Psychotherapy — out-patient clinic. Special education classroom—public school. Day care program, psychiatric. Placement—private boarding school—excluded because of behavior.

No. 20

*Presenting Problem:* Severely disabling phobias; fire-setting; profound depression; severe reading problems at school with reactive anxiety.

*Diagnosis:* Psychoneurosis. Dyslexia.

*Previous Interventions:* Family therapy — community mental health resource. Family therapy—family service agency.

No. 21

*Presenting Problem:* Elective mutism; school refusal; severe temper outbursts; destructive and threatening behavior.

*Diagnosis:* Psychoneurosis.

*Previous Interventions:* School special services. Psychiatric evaluation—child guidance clinic. Phychotherapy—out-patient clinic.

No. 22

*Presenting Problem:* Markedly aggressive behavior at home and in community; attempted to drown younger brother; fire-setting.

*Diagnosis:* Relatively affectionless personality.

*Previous Interventions:* School special services. Family therapy in community mental health clinic.

No. 23

*Presenting Problem:* Suicide attempt with severe threat to life.

*Diagnosis:* Psychoneurosis with depression.

*Previous Interventions:* Psychotherapy — community mental health resource.

No. 24

*Presenting Problem:* Fire-setting in community; excluded from school because of chronic unmanageable behavior.

*Diagnosis:* Encephalopathy with impulse disorder.

*Previous Interventions:* Psychiatric evaluations—in public school and several community clinics. Referred for placement in several group care programs in community but not accepted.



No. 25

*Presenting Problem:* Marked sexual discomfort with fetishism, transvestism and reactive anxiety; enuresis, intractable.

*Diagnosis:* Psychoneurosis with obsessive-compulsive and depressive symptoms.

*Previous Interventions:* School special services. Family therapy in community family service agency.

No. 26

*Presenting Problem:* Encopresis—intractable; impulsive temper outbursts; very poor peer relationships; unhappy and discouraged.

*Diagnosis:* Psychoneurosis, severe.

*Previous Interventions:* Nursery school. School special services. Family therapy—family service agency. Phychotherapy—out-patient clinic.

No. 27

*Presenting Problem:* Sadistic behavior toward younger sibling and animals—potentially dangerous; fire-setting at home and in neighborhood; previously hospitalized elsewhere because of child abuse—patient the victim.

*Diagnosis:* Psychoneurosis reactive to abuse.

*Previous Interventions:* Pediatric services of hospital in community.

No. 28

*Presenting Problem:* Repeated suicide attempts; setting fire to self.

*Diagnosis:* Psychoneurosis—with depression.

*Previous Interventions:* Hospitalization—public psychiatric hospital in community. Hospitalization—private psychiatric hospital in community.

No. 29

*Presenting Problem:* Chronic drug abuse with repeated overdoses; reactive confusion and deterioration.

*Diagnosis:* Psychoneurosis with chronic drug abuse.

*Previous Interventions:* School special services. Counselling in several drug treatment centers. Hospitalization in private psychiatric hospital. Emergency medical treatment for drug overdoses.

No. 30

*Presenting Problem:* Severe asocial withdrawal; bizarre talk and behavior in the community; inappropriate sexual behavior with exploitation.

*Diagnosis:* Schizoprhenia of adolescence.

*Previous Interventions:* School special services.

No. 31

*Presenting Problem:* Total refusal to eat or drink with life-threatening weight loss and dehydration; lifelong bizarre and nonadaptive behavior.

*Diagnosis:* Childhood Schizophrenia.

*Previous Interventions:* Speech therapy — community speech and hearing clinic. Neurological, psychiatric and psychological studies—repeated many times in numerous hospitals and clinics. Day care psychiatric program in community. Placement attempted in several community resources but refused because of behavior.

No. 32

*Presenting Problem:* Wandering in community with impulsive darting in front of moving cars and similar life-threatening behavior; severe aggressive acting-out at home and in the community; encopresis and enuresis.



*Diagnosis:* Encephalopathy—severe, chronic. Chronic deprivation and neglect.

*Previous Interventions:* School special services. Special education classroom in public school. Pediatric wards in community hospitals. Hospitalization in private psychiatric hospital. Protective services in community—numerous agencies. Placement attempted in several community resources but refused because of behavior. Committed as mentally ill to Hawthorn Center by Probate Court.

No. 33

*Presenting Problem:* Aggressive, physical attacks on younger siblings; fire-setting in the community; inability to attend public school.

*Diagnosis:* Psychoneourosis with depression. Chronic deprivation and neglect.

*Previous Interventions:* School special services. Foster home placement—relatives. Placement—in-patient special education program. Juvenile Court intervention. Hospitalization in private psychiatric hospital.

No. 34

*Presenting Problem:* Asocial withdrawal—severe; unable to attend to personal hygiene needs; sexual acting-out with younger siblings; outbursts of uncontrollable temper.

*Diagnosis:* Childhood schizophrenia.

*Previous Interventions:* School special services. Special education classroom in public school.

No. 35

*Presenting Problem:* Obesity, marked, with many serious medical complications; very negative self image and poor interpersonal relationships; academic learning difficulties.

*Diagnosis:* Psychoneurosis, severe. Dyslexia.

*Previous Interventions:* Psychotherapy—private practitioner. School special services.

No. 36

*Presenting Problem:* Severe depression with obsessive preoccupations with death; encopresis.

*Diagnosis:* Psychoneurosis with depression.

*Previous Interventions:* School special services. Family therapy in out-patient department of community hospital.

No. 37

*Presenting Problem:* Acute catatonic state—stupor.

*Diagnosis:* Schizophrenia of adolescence.

*Previous Interventions:* Family therapy in community mental health clinic. Day care in community psychiatric program. Hospitalization in psychiatric hospital in community.

No. 38

*Presenting Problem:* Life-long maladaptation with marked anxiety; severe temper tantrums in response to minimal frustration; inability to function in public school.

*Diagnosis:* Childhood schizophrenia.

*Previous Interventions:* School special services. Special education classroom in public school.

No. 39

*Presenting Problem:* Very unhappy and uncomfortable child; aggressive attacks on younger sibling; vandalism and stealing.

*Diagnosis:* Psychoneurosis. Chronic deprivation.

*Previous Interventions:* Numerous recommendations for help in community rejected by the mother.



No. 40

*Presenting Problem:* Fire setting in community; much destruction of property; encopresis and enuresis.

*Diagnosis:* Psychoneurosis. Chronic neglect.

*Previous Interventions:* Diagnostic studies in several out-patient clinics. Juvenile court interventions. Placement in group care program in community—excluded because of behavior. Day care in psychiatric facility—unable to adjust.

No. 41

*Presenting Problem:* Sadistic attacks on younger children; threats to stab mother; behavior unmanageable at home and in school.

*Diagnosis:* Relatively affectionless personality.

*Previous Interventions:* School special services. Pediatric hospital intervention. Counselling for family in community agency. Hospitalization—emergency admission to psychiatric hospital. Hospitalization—private psychiatric hospital in community.

No. 42

*Presenting Problem:* Unmanageable at home and at school; sexual acting-out in community; very unhappy and socially uncomfortable child.

*Diagnosis:* Psychoneurosis with depression.

*Previous Interventions:* School special services. Family therapy—out-patient clinic in community. Placement—private boarding school—financially prohibitive. Day care in psychiatric facility—failed to adjust.

No. 43

*Presenting Problem:* Attempted homicide; attempted suicide; fire-setting in community.

*Diagnosis:* Childhood schizophrenia. Encephalopathy.

*Previous Interventions:* Hospitalization in community psychiatric hospital. Juvenile Court interventions following attempted homicide and fire-setting. Committed as mentally ill to Hawthorn Center by Probate Court.

No. 44

*Presenting Problem:* Rage reactions constituting danger at home; generally infantile behavior and very poor peer relationships; uneven developmental pattern.

*Diagnosis:* Psychoneurosis, severe. Encephalopathy.

*Previous Interventions:* Diagnostic studies—hospital outpatient clinic. School special services. Family therapy—private practitioner.

No. 45

*Presenting Problem:* School refusal of more than two-year duration, unresponsive to numerous community intervention efforts.

*Diagnosis:* Psychoneurosis with severe phobias.

*Previous Interventions:* School special services. Family therapy in community mental health program.

No. 46

*Presenting Problem:* Severe rage reactions; physical aggression toward children and adults; unhappy child with extremely poor social skills.

*Diagnosis:* Psychoneurosis with marked emotional immaturity.

*Previous Interventions:* School special services. Protective services for family—many community agencies. Juvenile court interventions. Placement in residential group care program in community—excluded because of behavior.

No. 47

*Presenting Problem:* Suicide attempts; markedly agitated behavior with bizarre rituals and head banging; life-long pattern of maladaptation.



*Diagnosis:* Childhood schizophrenia.

*Previous Interventions:* School special services. Family therapy in community mental health clinic. Hospitalization in psychiatric unit of community hospital for emergency care.

No. 48

*Presenting Problem:* Autistic self absorption; bizarre behavior; congenital deafness.

*Diagnosis:* Childhood schizophrenia. Congenital deafness.

*Previous Interventions:* School special services. Special education classroom in public school. Diagnostic studies in numerous hospitals and other agencies. Family therapy in community mental health program. Placement in residential program for deaf children attempted but child refused admission because of mental illness.

No. 49

*Presenting Problem:* Self destructive behavior in reaction to frustration; marked aggression toward peers; unable to adapt in long series of foster homes.

*Diagnosis:* Encephalopathy with impulse disorder. Marked early neglect and diffusion in care.

*Previous Interventions:* Juvenile Court interventions. Placement in foster homes; at least seven. Placement in residential group care program in community—excluded because of behavior.

No. 50

*Presenting Problem:* Bizarre behavior since early childhood; severe asocial withdrawal; limited speech and language development with echolalia.

*Diagnosis:* Childhood schizophrenia.

*Previous Interventions:* Diagnostic studies in out-patient clinic of several community hospitals. Family therapy in community mental health center. Day care program in psychiatric facility in community.

No. 51

*Presenting Problem:* Very negative self image reflected in delinquent acting-out behavior; aggressive attacks on siblings; destruction of personal possessions during rage reactions.

*Diagnosis:* Psychoneurosis with depression.

*Previous Interventions:* School special services. Family therapy in community family service agency.

No. 52

*Presenting Problem:* Violent temper outbursts with minimal provocation; inability to attend school; enuresis—chronic, intractable.

*Diagnosis:* Psychoneurosis.

*Previous Interventions:* School special services. Family therapy in community mental health resource.

No. 53

*Presenting Problem:* Violent temper outbursts; severe academic learning difficulties; impaired motor coordination.

*Diagnosis:* Encephalopathy, severe with impulse disorder.

*Previous Interventions:* School special services. Special education classroom in public school. Juvenile Court interventions. Hospitalization in psychiatric hospital in community.



No. 54

*Presenting Problem:* Bizarre behavior pattern since early childhood; severe asocial withdrawal; speech and language limited to occasional echolalia; repetitive motor mannerisms; uncontrolled striking out when frustrated.

*Diagnosis:* Childhood Schizophrenia.

*Previous Interventions:* Day care in special education program in community. Day care in psychiatric hospital program.

No. 55

*Presenting Problem:* Suicide threats; progressive asocial withdrawal; gradual deterioration in general functioning.

*Diagnosis:* Psychoneurosis with severe depression.

*Previous Interventions:* School special services.

No. 56

*Presenting Problem:* Very unhappy, socially uncomfortable child; chronic negative acting-out behavior including stealing; traumatic sexual experiences.

*Diagnosis:* Psychoneurosis with depression.

*Previous Interventions:* School special services. Family therapy in community mental health agency.

No. 57

*Presenting Problem:* Inability to attend school; very negative self image with poor social skills; enuresis—chronic, intractable.

*Diagnosis:* Psychoneurosis with depression.

*Previous Interventions:* School special services.

No. 58

*Presenting Problem:* Repeated delinquency including breaking and entering; unable to attend school.

*Diagnosis:* Encephalopathy.

*Previous Interventions:* Special school services. Family therapy in community mental health agency. Placement in residential group care program—excluded because of behavior.

No. 59

*Presenting Problem:* Rapid onset of grossly disturbed behavior with hallucinations, delusions, bizarre reactions and "coma".

*Diagnosis:* Schizophrenia of adolescence.

*Previous Interventions:* Psychotherapy—private practitioner. Family therapy in community mental health clinic.

No. 60

*Presenting Problem:* Emergency admission — homicide attempt by setting fire to the family home; set fire to infant sibling's crib with infant in crib; set fire to brother's bed while brother asleep in bed; chronic enuresis.

*Diagnosis:* Psychoneurosis, severe.

*Previous Interventions:* None: no alternative to admission at time of referral because of severe emergency situation.

No. 61

*Presenting Problem:* Marked hypercativity with severe temper tantrums and destructive behavior; physical attacks on younger children.

*Diagnosis:* Encephalopathy with impulse disorder.

*Previous Interventions:* School special services. Family therapy in community mental health clinic. Day care in community mental health clinic—unable to adjust.

No. 62

*Presenting Problem:* Sexual difficulties in community—



transvestism; marked anxiety, social discomfort and desire for help.

*Diagnosis:* Psychoneurosis, severe.

*Previous Interventions:* School special services. Family therapy in community mental health agency.

No. 63

*Presenting Problem:* Fire setting at home and in community; unable to attend school; encopresis and enuresis, chronic intractable.

*Diagnosis:* Psychoneurosis.

*Previous Interventions:* Family therapy with private practitioner. School special services. Placement in residential group care program attempted but not possible because of severity of disturbance.

No. 64

*Presenting Problem:* Sadistic attacks on both children and adults using butcher knives; fire-setting in community.

*Diagnosis:* Relatively affectionless personality. Chronic deprivation and neglect.

*Previous Interventions:* Protective service—many community agencies. Family therapy in community mental health agency. Foster homes—all unsuccessful. Juvenile Court intervention. Hospitalization in private psychiatric hospital in community.

No. 65

*Presenting Problem:* Asocial withdrawal alternating with belligerent acting out; negative self image with very poor peer relationships; unable to attend school.

*Diagnosis:* Psychoneurosis, severe.

*Previous Interventions:* School special services. Family therapy in community mental health clinic. Day care in private program in community.

No. 66

*Presenting Problem:* Epilepsy—mixed seizure pattern; severe temper outbursts; many self destructive threats.

*Diagnosis:* Epilepsy, chronic, idiopathic. Psychoneurosis with depression.

*Previous Interventions:* Neurological and psychiatric studies—pediatric hospital in community. School special services.

No. 67

*Presenting Problem:* Mutism; regressed, primitive, unpatterned behavior.

*Diagnosis:* Uncertain — question of childhood schizophrenia or encephalopathy with mental retardation.

*Previous Interventions:* Nursery schools both public and private. Family therapy in community mental health agency. Consultations in community hospital leading to referral to Hawthorn Center.

No. 68

*Presenting Problem:* Marked hyperactivity with aggressive, destructive acting-out behavior in home, school and community; unhappy child with very negative self percept.

*Diagnosis:* Psychoneurosis.

*Previous Interventions:* Family therapy in community mental health agency. Special education in private specialized clinic.

No. 69

*Presenting Problem:* Physical attacks on younger children including threats with knives; aggressive sexual attacks on younger children; encopresis.

*Diagnosis:* Encephalopathy, chronic, severe. Chronic deprivation and neglect.



*Previous Interventions:* School special services. Family therapy in community mental health agency. Diagnostic studies in hospital out-patient clinic. Committed as mentally ill to Hawthorn Center by Probate Court.

No. 70

*Presenting Problem:* Sadistic behavior directed toward younger children; fire-setting—baby's crib—baby in crib; urination and defecation in closets at home and at school; aggressive play with knives, matches and axes; very unhappy, severely rejected child.

*Diagnosis:* Psychoneurosis. Severe neglect.

*Previous Interventions:* School special services. Special education classroom in public school. Day care in community mental health program.

No. 71

*Presenting Problem:* Fire-setting in community; severely impulsive aggressive behavior; functional blindness — familial.

*Diagnosis:* Encephalopathy, severe. Chronic deprivation and neglect.

*Previous Interventions:* School special services. Special education class in public school—excluded. Pediatric service, community hospital — ophthalmology and neurology studies and treatment. Juvenile Court intervention. Hospitalization in private psychiatric hospital in community.

No. 72

*Presenting Problem:* Suicide attempt — drug overdose; severe chronic depression; marked anxiety in reaction to sexual identity problems.

*Diagnosis:* Psychoneurosis, with severe depression.

*Previous Interventions:* Psychotherapy—private practitioner.

No. 73

*Presenting Problem:* Epilepsy, psychomotor; severely aggressive destructive episodes; threatening safety of others.

*Diagnosis:* Epilepsy, psychomotor.

*Previous Interventions:* School special services. Neurological studies—numerous in several hospital clinics. Special education therapy in community program.

No. 74

*Presenting Problem:* Severe acting-out behavior with much kicking and screaming; bizarre thought content; unable to attend school.

*Diagnosis:* Childhood schizophrenia.

*Previous Interventions:* Special school services. Day school, private: excluded because of behavior. Family therapy in community-private practitioner. Hospitalization in psychiatric unit of hospital in community.

No. 75

*Presenting Problem:* Suicidal preoccupations and threats; victim of sexual molestation; beginning anorexia.

*Diagnosis:* Psychoneurosis with severe depression.

*Previous Interventions:* None known.

No. 76

*Presenting Problem:* Bizarre, aggressive and life-threatening behavior; suicide attempt—drug overdose; sexually exploited in community.

*Diagnosis:* Schizophrenia of adolescence.

*Previous Interventions:* School special services. Special education classroom. Hospitalizations in four psychiatric or pediatric hospitals. Committed as mentally ill to Hawthorn Center by Probate Court.



No. 77

*Presenting Problem:* Severe temper outbursts with minimal provocation; academic learning difficulties; unable to attend public school; very negative self image with poor peer relationships.

*Diagnosis:* Encephalopathy with impulse disorder. Psychoneurosis. Dyslexia.

*Previous Interventions:* School special services. Family therapy—hospital out-patient clinic in community. Private tutoring in community.

No. 78

*Presenting Problem:* Increasingly pervasive suicide preoccupations and threats; severe depression; asocial withdrawal.

*Diagnosis:* Phychoneurosis, with severe depression.

*Previous Interventions:* Psychotherapy in community—private practitioner.

No. 79

*Presenting Problem:* General deterioration in adjustment; increasingly aggressive, unmanageable behavior; very negative self image.

*Diagnosis:* Psychoneurosis with depression.

*Previous Interventions:* School special services. Special classroom in public school. Family therapy in community mental health agency.

No. 80

*Presenting Problem:* Encopresis, severe, intractable with fecal retention and secondary bowel pathology.

*Diagnosis:* Psychoneurosis.

*Previous Interventions:* Family therapy in community mental health agency.

No. 81

*Presenting Problem.* Acute psychosis probably induced by drug abuse; delusions of omnipotence with bizarre threatening behavior; emergency admission to hospital indicated.

*Diagnosis:* Acute psychosis probably toxic.

*Previous Interventions:* None — at the time of referral there was no alternative to hospitalization. Committed as mentally ill to Hawthorn Center by Probate Court.

No. 82

*Presenting Problem:* Juvenile diabetes with suicide preoccupations and attempts; refusal to cooperate in diabetes treatment regime, attempting to induce diabetic coma with suicide intent.

*Diagnosis:* Juvenile diabetes. Psychoneurosis with severe depression.

*Previous Interventions:* Diagnostic studies — private practitioner in community. Family therapy in out-patient clinic of community hospital. Crisis center in community hospital for suicide attempt.

No. 83

*Presenting Problem:* Severe asocial withdrawal since early childhood; no speech or language for communications; severe temper outbursts with destructive behavior and fire-setting; unable to attend public school.

*Diagnosis:* Childhood Schizophrenia.

*Previous Interventions:* Diagnostic studies in out-patient clinic of community hospital. Nursery school in community. Committed as mentally ill to Hawthorn Center by Probate Court.



No. 84

*Presenting Problem:* Inability to eat with life-threatening weight loss; bizarre exercise patterns; repeated suicide threats; suicide attempt.

*Diagnosis:* Anorexia Nervosa, severe.

*Previous Interventions:* Psychotherapy — private practitioner in community.

No. 85

*Presenting Problem:* Somatic complaints — numerous, disabling; negative self image and poor peer relationships; frequently unable to attend school; chronic academic underachievement.

*Diagnosis:* Psychoneurosis with depression. Encephalopathy.

*Previous Interventions:* School special services. Special education classroom in public school. Juvenile Court interventions. Family protective services in community.

No. 86

*Presenting Problem:* Diffuse, disorganized behavior since infancy; very limited speech and language development; severe asocial withdrawal.

*Diagnosis:* Encephalopathy, severe.

*Previous Interventions:* Diagnostic studies in several hospital out-patient clinics. Speech and hearing therapy in community clinic. Day care in two special education programs in community.

No. 87

*Presenting Problem:* Aggressive outbursts threatening safety; marked hyperactivity; uneven growth pattern with reactive anxiety and social discomfort.

*Diagnosis:* Encephalopathy. Psychoneurosis.

*Previous Interventions:* School special services. Special education classroom in public school. Family therapy in community mental health agency.

No. 88

*Presenting Problem:* Almost total asocial withdrawal since infancy; impulsive sadistic acting out since age 2 years; no speech or language development.

*Diagnosis:* Childhood schizophrenia.

*Previous Interventions:* Diagnostic studies in out-patient clinics of several hospitals in community. Protective services in community. Nursery school in community — excluded because of behavior. Committed as mentally ill to Hawthorn Center by Probate Court.

No. 89

*Presenting Problem:* Sexual acting-out in community — attacks on younger children; chronic severe delinquency including breaking and entering; fire-setting.

*Diagnosis:* Psychoneurosis, severe. Chronic deprivation and neglect.

*Previous Interventions:* School special services. Juvenile Court interventions. Placement in residential group care setting in community — excluded because of behavior.

No. 90

*Presenting Problem:* Self imposed starvation with life threatening weight loss; inability to attend school for more than four months; progressive deterioration in general health.

*Diagnosis:* Anorexia Nervosa.

*Previous Interventions:* Pediatric interventions — intensive measures. Psychotherapy, intensive, in hospital out-patient clinic.



No. 91

*Presenting Problem:* Bizarre behavior since early childhood; idiosyncratic speech pattern with echolalia; severe temper outbursts with minimal provocation; many rituals including long periods of head banging.

*Diagnosis:* Childhood schizophrenia.

*Previous Interventions:* School special services. Special education classroom in public school — excluded. Day care special education program in community — excluded because of behavior. Day care in community mental health program.

No. 92

*Presenting Problem:* Severe depression with inertia; inability to attend school; suicide preoccupation.

*Diagnosis:* Psychoneurosis, severe; Obsessive-compulsive.

*Previous Interventions:* Family therapy in psychiatric hospital out-patient clinic. Psychotherapy — private practitioner. Family therapy in community mental health clinic.

No. 93

*Presenting Problem:* Aggressive, destructive, threatening behavior at home, in school and in community; Chronic delinquency with stealing and vandalism; primitive behavior such as defecating in closets.

*Diagnosis:* Psychoneurosis. Chronic deprivation and neglect.

*Previous Interventions:* School special services. Juvenile Court interventions. Hospitalization in private psychiatric hospital in community. Committed as mentally ill to Hawthorn Center by Probate Court.

No. 94

*Presenting Problem:* Suicide attempt during rage reaction; severe temper outbursts with head banking; unable to attend public school.

*Diagnosis:* Encephalopathy with borderline mental retardation.

*Previous Interventions:* School special services. Juvenile Court interventions. Placements: four foster homes — excluded from all because of behavior. Placement: Residential special education program — excluded because of behavior.

No. 95

*Presenting Problem:* Severe, chronic aggression impairing all relationships and placements; marked hyperactivity and lack of impulse control.

*Diagnosis:* Encephalopathy with impairment in academic learning. Early deprivation and neglect.

*Previous Interventions:* Placements: series of foster homes — excluded from all because of behavior. Juvenile Court interventions. Placement in residential group care program in community — unable to adjust.

No. 96

*Presenting Problem:* Very negative self image and personal discomfort; uncontrollable temper outbursts with threats to safety; marked social isolation and rejection; academic failure despite very high potential.

*Diagnosis:* Psychoneurosis.

*Previous Interventions:* School special services. Family therapy in community mental health agency. Placement in residential group care program in community — unable to adjust.



No. 97

*Presenting Problem:* Asthma — chronic, severe with marked anxiety; encopresis and enuresis; very poor impulse control; very uncomfortable in all areas of adaptation.

*Diagnosis:* Psychoneurosis with bronchial asthma.

*Previous Interventions:* Pediatric intervention over period of years. School special services. Family therapy — private practitioner. Family therapy in hospital out-patient clinic.

No. 98

*Presenting Problem:* Suicide attempt following repeated threats; profound general discouragement.

*Diagnosis:* Psychoneurosis, severe depression.

*Previous Interventions:* School special services. Placement: foster home in community — unsuccessful. Placement: residential group care program in community. Placement: second residential group care program in community. Psychotherapy, emergency care, crisis-suicide center in community hospital.

No. 99

*Presenting Problem:* Chronic aggressive behavior impairing adjustment at home, in school and in the community.

*Diagnosis:* Psychoneurosis. Chronic deprivation and neglect.

*Previous Interventions:* School special services. Family therapy — private practitioner in community.

No. 100

*Presenting Problem:* Numerous disabling fears, including fear of attack from dead relatives; inability to eat because of fear that food is poisoned; hallucinations with reactive attacks on peers — knives and scissors.

*Diagnosis:* Schizophrenia of adolescence.

*Previous Interventions:* School special services. Family therapy in out-patient clinic of hospital in community. Hospitalization in public psychiatric hospital.

No. 101

*Presenting Problem:* Gradual deterioration in adjustment at all levels; inability to attend public school or special day school in community; severe anxiety and social discomfort.

*Diagnosis:* Childhood schizophrenia.

*Previous Interventions:* School special services. Family therapy — private practitioner in community. Day care in psychiatric program in community.

No. 102

*Presenting Problem:* Post-traumatic regression and impulsivity — head injury with coma; severe temper outbursts; fire-setting in community.

*Diagnosis:* Encephalopathy, post-traumatic.

*Previous Interventions:* Pediatric intervention over long period. Family therapy — private practitioner in community. Placement: In foster home — unsuccessful. Hospitalization in private psychiatic hospital.

No. 103

*Presenting Problem:* Fire-setting at home and in community; chronic enuresis; aggressive outbursts interferring with all relationships.

*Diagnosis:* Psychoneurosis with depression.

*Previous Interventions:* School special services. Family therapy in community mental health clinic. Placement in private boarding school — excluded because of behavior. Hospitalization in public psychiatric hospital.



No. 104

*Presenting Problem:* Acute onset of markedly bizarre behavior with delusions; unable to sleep, disoriented, agitated; picked up by police because of bizarre behavior in the community.

*Diagnosis:* Schizophrenia of adolescence.

*Previous Interventions:* School special services. Family therapy in outpatient clinic of psychiatric hospital. Hospitalization in psychiatric unit of community hospital. Hospitalization in private psychiatric hospital.

No. 105

*Presenting Problem:* Impulsive aggressive behavior impairing adaptation in all areas; severe temper outbursts in response to minimal frustration; marked unhappiness and negative self percept.

*Diagnosis:* Psychoneurosis, severe.

*Previous Interventions:* Family therapy in community mental health program. Psychotherapy — private therapist in the community.

No. 106

*Presenting Problem:* Self mutilation attempts — castration; severe depression with increasing preoccupation with harm to self.

*Diagnosis:* Psychoneurosis with depression.

*Previous Interventions:* School special services. Pediatric emergency care for self mutilation. Hospitalization in public psychiatric hospitals—two hospitals. Hospitalization in private psychiatric hospital. Committed as mentally ill to Hawthorn Center by Probate Court.

No. 107

*Presenting Problem:* Profound regression in all areas of

function; self mutilation, chronic, severe; loss of all meaningful speech; severe asocial withdrawal.

*Diagnosis:* Childhood schizophrenia.

*Previous Interventions:* Pediatric interventions in hospital out-patient clinic. Family therapy in community mental health agency. Counselling in community parents' association. Day care in community psychiatric program.

No. 108

*Presenting Problem:* Fire-setting in community with severe danger to life; admitted for emergency study.

*Diagnosis:* Psychoneurosis. Dyslexia.

*Previous Interventions:* School special services. Speech therapy in community clinic. Tutoring—remedial reading in community.

No. 109

*Presenting Problem:* Encopresis—chronic, intractable; general emotional immaturity with marked social incompetence.

*Diagnosis:* Psychoneurosis, severe.

*Previous Interventions:* Pediatric intervention—unsuccessful. School special services.

No. 110

*Presenting Problem:* Aggressive acting-out behavior impairing adjustment at home, in school and in community; chronic underachievement in school with reactive anxiety and depression.

*Diagnosis:* Encephalopathy—post-encephalitis. Phychoneurosis with depression.

*Previous Interventions:* School special services. Diagnostic studies—four studies in community agencies. Pediatric interventions, intensive.



No. 111

*Presenting Problem:* Fire-setting in community; sexual acting-out with younger children; severe behavior problem at home, in school and in the community; very severe academic learning difficulties.

*Diagnosis:* Psychoneurosis, severe. Dyslexia, severe.

*Previous Interventions:* School special services. Family therapy in community mental health clinic. Family therapy —private practitioner in the community.

No. 112

*Presenting Problem:* Chronic pattern of poor adjustment and need for much special help in all areas; impulsive acting-out behavior impairing all relationships.

*Diagnosis:* Relatively affectionless personality. Chronic deprivation and neglect.

*Previous Interventions:* Placements: Several foster homes. Protective services in community—many agencies. Family therapy in hospital outpatient clinic. Juvenile Court interventions. Placement in residential group care program in community—excluded because of behavior.

No. 113

*Presenting Problem:* Fire-setting in community; uncontrollable temper outbursts with threats to safety.

*Diagnosis:* Psychoneurosis, severe.

*Previous Interventions:* School special services. Juvenile Court intervention. Family therapy in two community mental health programs.

No. 114

*Presenting Problem:* Aggressive, destructive acting-out behavior at home, in school and in the community; hyperactivity interferring with adjustment in all areas.

*Diagnosis:* Encephalopathy with impulse disorder. Psychoneurosis with anxiety.

*Previous Interventions:* School special services. Special education classroom in public school. Therapy in community special education program. Pediatric intervention, including neurological studies, over several years.

No. 115

*Presenting Problem:* Fire-setting in the community; hair pulling, chronic; severe night terrors and sleep walking.

*Diagnosis:* Psychoneurosis, severe.

*Previous Interventions:* School special services. Diagnostic studies in two hospital programs. Day care in psychiatric treatment program.

No. 116

*Presenting Problem:* Very unhappy in all relationships, including very negative self percept; reactive, hostile and aggressive behavior at home and at school; severe academic learning problems.

*Diagnosis:* Psychoneurosis, severe. Dyslexia.

*Previous Interventions:* School special services. Family therapy in community mental health clinic. Family therapy in psychiatric hospital outpatient clinic.

No. 117

*Presenting Problem:* Encopresis and enuresis, chronic, intractable; obesity; severe problems in academic learning; marked emotional immaturity.

*Diagnosis:* Psychoneurosis, severe. Dyslexia.

*Previous Interventions:* School special services. Special education classroom in public schools.



No. 118

*Presenting Problem:* Asocial withdrawal and bizarre preoccupations and behavior; unable to participate in group activities; very poor relationships with peers; unable to attend school periodically.

*Diagnosis:* Childhood schizophrenia.

*Previous Interventions:* Family therapy in community mental health program. Family therapy in second community mental health program.

No. 119

*Presenting Problem:* Fire-setting in community; encopresis and enuresis, chronic; self mutilation with primitive acting-out behavior.

*Diagnosis:* Relatively affectionless personality. Chronic deprivation and neglect.

*Previous Interventions:* Pediatric interventions. School special services. Family therapy in community mental health clinic. Special education therapy in community program.

No. 120

*Presenting Problem:* Suicide attempt; chronic depression with frequent crying spells, uncontrolled; inability to sleep.

*Diagnosis:* Psychoneurosis with depression.

*Previous Interventions:* School special services. Family therapy in community mental health program.

No. 121

*Presenting Problem:* Aggressive acting-out behavior impairing relationships at all levels; very negative self image with reactive anxiety and discomfort.

*Diagnosis:* Encephalopathy. Psychoneurosis.

*Previous Interventions:* School special services. Family therapy in community mental health clinic.

No. 122

*Presenting Problem:* Suicide preoccupations reactive to death in family; poor academic achievement with reactive counter-aggression, impairing relationships.

*Diagnosis:* Psychoneurosis with depression. Dyslexia.

*Previous Interventions:* School special services.

No. 123

*Presenting Problem:* Very unhappy child, reacting with chronic delinquent behavior; severe sleep disturbance; severe underachievement at school.

*Diagnosis:* Psychoneurosis with depression.

*Previous Interventions:* Family therapy in community out-patient treatment program.

No. 124

*Presenting Problem:* Very negative self image with reactive chronic negative, acting-out behavior; severe temper tantrums; obese; enuretic.

*Diagnosis:* Psychoneurosis.

*Previous Interventions:* School special services.

No. 125

*Presenting Problem:* Suicide attempt—drug overdose; long history of hysterical acting-out episodes; previous suicide attempts.

*Diagnosis:* Psychoneurosis with hysteria.

*Previous Interventions:* School special services. Family therapy in community mental health agency. Placement in residential group care program stressing special education—excluded because of behavior. Hospitalization—community hospital: emergency care following suicide attempts. Committed as mentally ill to Hawthorn Center by Probate Court.



No. 126

*Presenting Problem:* Very unhappy child, reacting with chronic aggressive behavior; encopresis, chronic; severe academic underachievement.

*Diagnosis:* Psychoneurosis.

*Previous Interventions:* School special services. Family therapy—private practitioner in community.

No. 127

*Presenting Problem:* Chronic aggressive acting-out behavior; negative self image interferring with all relationships.

*Diagnosis:* Psychoneurosis.

*Previous Interventions:* Diagnostic studies in two hospital out-patient departments — psychiatric. School special services. Remedial tutoring in private clinic in community. Placement in private boarding school — excluded because of behavior.

No. 128

*Presenting Problem:* Fire-setting in community; inability to adapt in adoptive home with reactive severe acting-out behavior; inability to attend public school; moderately severe hearing loss, post-rubella.

*Diagnosis:* Psychoneurosis with very negative self-image.

*Previous Interventions:* Family therapy in community family service agency. Placement in residential group care program in community.

No. 129

*Presenting Problem:* Primitive disorganized behavior reactive to life-long rejection; enuresis, chronic; marked hyperactivity with aggressive acting-out and destructiveness.

*Diagnosis:* Relatively affectionless personality. Chronic deprivation and neglect.

*Previous Interventions:* Juvenile Court involvement. Placements in at lease seven foster homes—all unsuccessful. Placement in residential group care program in community — excluded because of behavior.

No. 130

*Presenting Problem:* Severe reactive depression following desertion by mother; suicide preoccupations and threats; epilepsy.

*Diagnosis:* Psychoneurosis, reactive depression. Epilepsy.

*Previous Interventions:* Juvenile Court interventions. Diagnostic studies in community hospital out-patient clinic. Placement in home of relative — unsuccessful. Placement in agency foster home — unsuccessful. Psychotherapy in community mental health program.

No. 131

*Presenting Problem:* Unmanageable behavior at home and at school with many threats of violence; involvement in drug abuse with reactive confusional states.

*Diagnosis:* Psychoneurosis.

*Previous Interventions:* Family therapy in community mental health clinic. Psychotherapy in hospital out-patient clinic. Efforts to find group placement in community unsuccessful.

No. 132

*Presenting Problem:* Fire-setting in community with great danger to safety; emergency admission indicated and implemented.

*Diagnosis:* Psychoneurosis, chronic. Chronic deprivation and neglect.



*Previous Interventions:* Juvenile Court Intervention. Psychotherapy in community family service agency. Placements in long series of foster homes with numerous replacements necessary.

No. 133

*Presenting Problem:* Very negative self image with reactive uncontrolled aggressive behavior at home, in school and in community; very low academic achievement; marked emotional immaturity.

*Diagnosis:* Psychoneurosis. Dyslexia.

*Previous Interventions:* School special services. Special education in classroom in public school. Family therapy in community family service agency.

No. 134

*Presenting Problem:* Obesity with reactive negative self percept and acting-out behavior; marked emotional immaturity; negative behavior alienating peers and impairing all relationships.

*Diagnosis:* Psychoneurosis.

*Previous Interventions:* Family therapy — private practitioner in community. School special services. Hospitalization in psychiatric unit of community hospital.

No. 135

*Presenting Problem:* Emergency admission: dangerous physical attack on younger child; fire-setting in community.

*Diagnosis:* Psychoneurosis.

*Previous Interventions:* School special services.

No. 136

*Presenting Problem:* Negative self image with reactive severe acting-out behavior; unmanageable at home with progressive deterioration in total adjustment; involvement in drug abuse.

*Diagnosis:* Psychoneurosis.

*Previous Interventions:* School special services. Counselling in local community agency.

No. 137

*Presenting Problem:* Negative, destructive and threatening behavior at home, in school and in community; negative self image with reactive counteraggression.

*Diagnosis:* Psychoneurosis. Early deprivation and neglect.

*Previous Interventions:* School special services. Family therapy in community mental health clinic. Family therapy in out-patient clinic of community hospital. Placement attempted in residential group care programs in community — admission refused because of severity of behavior problems.

No. 138

*Presenting Problem:* Violent temper outbursts reactive to minimal frustration; marked hyperactivity; ritualistic, inappropriate, compulsive behavior.

*Diagnosis:* Encephalopathy. Chronic deprivation and neglect.

*Previous Interventions:* Juvenile Court interventions. Placements in a series of foster homes. Diagnostic studies in out-patient clinic of two psychiatric hospitals. In special education classroom of public school.

No. 139

*Presenting Problem:* Dwarfism with reactive depression and great discouragement; hyperactivity with poor impulse control.

*Diagnosis:* Endocrine dyscrasia with dwarfism. Chronic deprivation and neglect.



*Previous Interventions:* Pediatric intervention — endocrinology clinics. School special services. Family counselling in out-patient clinic of psychiatric hospital.

No. 140

*Presenting Problem:* Suicide attempt — drug overdose; involvement in drug abuse; depression with reactive acting-out behavior.

*Diagnosis:* Psychoneurosis — depression.

*Previous Interventions:* School special services. Family therapy in community family service agency.

No. 141

*Presenting Problem:* Bizarre behavior, from early childhood; marked asocial withdrawal alternating with episodes of excitement; idiosyncratic language; unable to attend school in community.

*Diagnosis:* Childhood schizophrenia.

*Previous Interventions:* School special services. Family therapy in community mental health agency. Hospitalization in psychiatric hospital in community.

No. 142

*Presenting Problem:* Suicide threats; fire-setting in community; hyperactive, impulsive, often uncontrolled behavior.

*Diagnosis:* Encephalopathy with impulse disorder. Chronic deprivation and neglect.

*Previous Interventions:* Family therapy in community mental health agency. Placement in residential group care program with stress of special education — excluded because of behavior. Placements: numerous foster homes and relatives' homes — all unsuccessful.

No. 143

*Presenting Problem:* Impulsive, negative acting-out behavior at home, in school and in community; negative self percept with marked emotional immaturity.

*Diagnosis:* Psychoneurosis — emotional immaturity.

*Previous Interventions:* Diagnostic studies in psychiatric hospital out-patient clinic. Special education classroom in private day school. Family therapy—private practitioner in community.

No. 144

*Presenting Problem:* Bizarre, unpredictable behavior such as darting in front of moving cars; attempts at self mutilation; unable to attend public shcool.

*Diagnosis:* Childhood schizophrenia.

*Previous Interventions:* Diagnostic studies in several community mental health clinics. Diagnostic studies by several private practitioners in community. Family therapy in community mental health clinic. Day care in community psychiatric day care program.

No. 145

*Presenting Problem:* Severely aggressive and destructive outbursts with minimal provocation; violence directed toward younger children, with severe threat to safety.

*Diagnosis:* Psychoneurosis.

*Previous Interventions:* Juvenile Court Involvements. Family counselling in out-patient clinic of community hospital. Placement in private psychiatric hospital. Committed as mentally ill to Hawthorn Center by Probate Court.

No. 146

*Presenting Problem:* Asocial withdrawal alternating with episodes of aggressive acting-out; strong feelings of rejection with reactive negativism; marked academic underachievement.



*Diagnosis:* Psychoneurosis with depression. Encephalopathy.

*Previous Interventions:* Diagnostic studies in out-patient clinic of community hospital. School special services.

No. 147

*Presenting Problem:* Uncontrollable rages at home, in school and in community; unable to attend public school; total illiteracy.

*Diagnosis:* Encephalopathy, with impulse disorder. Dyslexia, severe. Chronic deprivation and neglect.

*Previous Interventions:* School special services. Special education classroom in public school. Protective services — many community agencies. Family therapy in psychiatric hospital out-patient clinic in community. Hospitalization in psychiatric unit of community hospital.

No. 148

*Presenting Problem:* Sadistic attacks on younger children and animals; chronic destructive acting-out behavior impairing adjustment at every level; inability to adjust in numerous placements in the community.

*Diagnosis:* Relatively affectionless personality. Chronic deprivation and neglect.

*Previous Interventions:* Juvenile Court interventions. Placements in numerous foster homes — all unsuccessful. Hospitalization in psychiatric hospital in community. Placement in residential group care program in community — excluded because of behavior. Hospitalization in private psychiatric hospital in community.

No. 149

*Presenting Problem:* Very violent impulsive behavior with physical assult on peers and adults; unable to attend public school; anxious and frightened in reaction to lack of impulse control.

*Diagnosis:* Encephalopathy, severe, with impulse disorder.

*Previous Interventions:* School special services. Special education classroom in public school. Family therapy in community mental health agency. Hospitalization in children's unit of psychiatric hospital.

## MICHIGAN MENTAL HEALTH CODE

*Formal Voluntary Admission Provisions*

MSA 14.800(415)—(420)

MCLA 330.1415—.1420

Sec. 415(1) An individual 18 years of age or over may be hospitalized as a formal voluntary patient if he executes an application for hospitalization as a formal voluntary patient and if the director of the hospital deems him clinically suitable for that form of hospitalization.

(2) An individual less than 18 years of age may be hospitalized as a formal voluntary patient if an application for his hospitalization as a formal voluntary patient is executed by his parent, guardian, or, in the absence of his parent or guardian, a person in loco parentis, and if the director of the hospital deems him clinically suitable for that form of hospitalization.

Sec. 416 The formal application shall contain in large type and simple language the substance of sections 417 to 420. Upon hospitalization, the rights set forth in the application shall be orally communicated to the patient and



to the person who executed the application. In addition, a copy of the application shall be given to each of the aforementioned persons and to one other person designated by the patient.

Sec. 417(1) Objection may be made to the hospitalization of a minor of any age under section 415(2). Objections may be filed with the court by a person found suitable by the court or by the patient himself if he is at least 13 years of age. The objection shall be made in writing to the court not more than 30 days after hospitalization of the patient, and may be made subsequently at any 3-month interval following the date of the original objection or, if an original objection was not made, at any 3-month interval following the date of hospitalization.

(2) If the patient informs the hospital that he desires to object to his hospitalization, the hospital shall assist him in properly submitting the objection to the court.

(3) Upon receipt of an objection, the court shall schedule a hearing to be held within 7 days, excluding Sundays and holidays. The court shall notify the objecting person, the patient, the person who executed the application, and the director of the hospital of the time for the hearing.

(4) The hearing shall be governed by those provisions of sections 451 to 465, including the appointment of counsel and an independent medical evaluation, which the court deems necessary to ensure that all pertinent information is brought to its attention, and by the provisions of this section.

(5) Unless the court sustains the objection and orders the discharge of the patient, the hospital may continue to hospitalize the patient, no court order shall be entered, and the objection shall be terminated.

(6) The court shall sustain the objection and order the discharge of the patient if the patient is not in need of the treatment which is available at the hospital or if a treatment program which does not involve hospitalization is available and appropriate for the patient.

(7) Unwillingness or inability of the parent, guardian, or person in loco parentis to provide for the management, care, or residence of the patient shall not be grounds for refusing to sustain the objection and order discharge, but in that event the objecting person may, or a person authorized by the court shall, promptly file a petition under the neglect provisions of the juvenile code to ensure that appropriate management, care, or residence is provided.

Sec. 418 If a hospital has officially agreed to hospitalize a minor, but hospitalization has been deferred until a subsequent date, an objection to hospitalization of the minor may be made prior to hospitalization of the minor and shall be governed by section 417. If the objection is sustained by the court, the minor shall not be hospitalized.

Sec. 419(1) Except as is provided in section 420, a formal voluntary patient 18 years of age or over shall not be hospitalized more than 3 days, excluding Sundays and holidays, after he gives written notice of his intention to terminate his hospitalization and leave the hospital.

(2) Except as is provided in section 420, a formal voluntary patient less than 18 years of age shall not be hospitalized more than 3 days, excluding Sundays and holidays, after his parent, guardian, or person in loco parentis gives written notice of his intention to terminate the hospitalization and to remove the patient from the hospital.

(3) When the hospital is told of an intention to terminate hospitalization under subsection (1) or (2), it shall promptly supply the written form which is required.



Sec. 420 If a written notice of termination of hospitalization is given to a hospital under section 419, if the notice is not withdrawn, and if the director determines that the patient is a person requiring treatment as defined in section 401 and should remain in the hospital, the director or other suitable person shall within 3 days, excluding Sundays and holidays, of the hospital's receipt of the notice file an application with the court which complies with section 423. The application shall be accompanied by the certificates of 2 physicians, at least one of whom shall be a psychiatrist. If an application is filed, the hospital may continue hospitalization of the patient pending hearings convened pursuant to sections 450 to 456.

Supreme Court, U. S.
FILED
JUN 16 1976
MICHAEL RODAK, JR., CLERK

IN THE

# Supreme Court of the United States

## No. A-75-1064.

JACK B. KREMENS, Individually and as Hospital Director of Haverford State Hospital; FRANK S. BEAL, Individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; WILLIAM B. BEACH, JR., Individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,
*Appellants,*

*v.*

KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND; Minors, Through Their Next Friend, Individually and on Behalf of All Others Similarly Situated,
*Appellees.*

Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania.

## BRIEF OF THE DEVEREUX FOUNDATION, THE MELMARK HOME INC., THE WOODS SCHOOLS, AND THE ALLEGHENY VALLEY SCHOOL FOR EXCEPTIONAL CHILDREN AS AMICI CURIAE.

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## CONSENT OF THE PARTIES.

All parties to this litigation, by their attorneys, have consented to the filing of this brief. Their consents are on file with the Clerk of this Court.

## INTEREST OF THE *AMICI*.

*Amici* are private, non-profit state-chartered corporate organizations engaged in providing residential treatment, training and educational services to the developmentally disabled and emotionally disturbed through the private sector. These institutions are similar to the private secondary schools which have been in existence throughout the United States since its founding. These organizations have all depended on private philanthropy for their creation, development and growth. They are not state agencies. They meet certain state education standards and regulations in order to be licensed by the Pennsylvania Department of Public Welfare to operate a facility for the mentally handicapped and to be licensed as private academic schools by the Commonwealth of Pennsylvania, Department of Education, State Board of Private Academic Schools; otherwise, they are not subject to direct control of any state agency. In other words, Pennsylvania does not have operational control over *amici* and others similarly situated.

The Devereux Foundation, established in 1912, is a Pennsylvania non-profit corporation duly qualified in the States of Arizona, Arkansas, California, Connecticut, Georgia, Massachusetts, Maine, and Texas.

The Melmark Home Inc. is a Delaware non-profit corporation duly qualified in Pennsylvania which began operations in 1966, with its principal office in Newtown Township, Delaware County, Pennsylvania.

The Woods School is a Pennsylvania non-profit corporation established in 1913 with its only facility located on a 300 acre tract in Langhorne, Bucks County, Pennsylvania.

The Allegheny Valley School For Exceptional Children is a Pennsylvania non-profit corporation founded on August 31, 1960.



All *amici* have enrolled children in residence under the age of eighteen years whose parents reside in Pennsylvania and other states. These children have been enrolled *voluntarily* with *amici* by their parents, after careful evaluation, because of the particular expertise developed and acquired by each for the care of exceptional children. Exceptional children are collectively classified as developmentally disabled, which includes the emotionally disturbed, mentally retarded, cerebral palsied, multi-handicapped and neurologically disfunctioned. All children may be withdrawn from the facilities at any time by the parents or persons in *loco parentis* and no child is retained in any of the facilities against his will.

The *amici* exist to enable parents to secure outstanding care, training and education for their children, and to aid the children themselves through specialized and advanced techniques for the care and education of the developmentally disabled. The order of the Court below serves to prohibit any admission to the facilities of *amici* without a full adversary hearing—a hearing which will inevitably dissuade parents from seeking proper care and treatment for their children and possibly exacerbate the child's condition, rendering care and education more difficult, if not impossible. Parent, child and institution should cooperate for the development of the exceptional child. Any order which places the parent and child in an adversary relation is damaging to and interfers with the institution's effort to aid the child. The *amici* believe that these consequences threaten their ability to serve both parents and children. For these reasons, the *amici* submit this brief to urge this Court to reverse the decision of the court below.

## STATEMENT.

The facts and previous decisions in this case are detailed in the brief of appellants and we restrict ourselves to a summary statement.

The Complaint below was instituted on November 16, 1972 on behalf of the named plaintiffs and "all persons under eighteen years of age who have been, are, or may be admitted or committed to Haverford State Hospital and all other *state* mental health facilities under the challenged provisions of the state statute." (emphasis added). The *amici,* as *private* institutions offering services to the developmentally disabled and mentally handicapped in Pennsylvania, were neither notified of the commencement of the action nor offered an opportunity to participate in the proceedings below. By Order dated April 29, 1974, the court below confirmed the class, and on November 17, 1975, entered its Final Order, paragraph 1 of which found that the action was properly maintained as a class action on behalf of "all children eighteen years of age or younger who have been, are, or may be admitted or committed to mental health or mental retardation facilities in Pennsylvania under the Pennsylvania Mental Health and Mental Retardation Act of 1966. 50 P. S. §§ 4402 and 4403 (§§ 402 and 403)." Thus, although none of the named plaintiffs had been admitted or committed to a private, as opposed to state, mental institution, and although the Complaint sought relief only on behalf of those admitted to state facilities, the Final Order nonetheless appears to apply to all voluntary admissions to private mental facilities in Pennsylvania.

As the result of the procedure followed below, *amici* were deprived of the opportunity to participate in proceedings which directly affect the manner in which its students are admitted. *Amici,* as private facilities provid-



ing valuable mental health/mental retardation services to children at the request of their parents were unable to introduce testimony as to their procedures with respect to voluntary admissions of persons under eighteen years of age, the effects of a full adversary hearing on the ability of parents to obtain adequate care for their children and the ability of *amici* to provide adequate care and training after such a hearing.

## ARGUMENT.

### I. Parents Have a Substantive Right, as Well as a Duty, to Control the Way in Which Their Minor Children Are Raised.

The right of parents to exercise control over the upbringing of their children has long been recognized as a fundamental tenet of the American way of life. *Meyer v. Nebraska*, 262 U. S. 390 (1923). In *Pierce v. Society of Sisters*, 268 U. S. 510, 534-35 (1925), in striking down a state compulsory public education act, this Court held:

> "Under the doctrine of Meyer v. Nebraska, 262 U. S. 390 (1923), we think it entirely plain that the Act of 1922 unreasonably interferes with the liberty of parents and guardians to direct the upbringing and education of children under their control. . . . The child is not the mere creature of the state; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations."

This Court has repeatedly reaffirmed parental assertions of the right to direct the upbringing and education of children under their control. In *Stanley v. Illinois*, 405 U. S. 645, 651 (1972), this Court stated:

> "The Court has frequently emphasized the importance of the family. The rights to conceive and to raise one's children have been deemed 'essential,' Meyer v. Nebraska, 262 U. S. 390, 399, 43 S. Ct. 625, 626, 67 L. Ed. 1072 (1923), 'basic civil rights of man,' Skinner v. Oklahoma, 316 U. S. 535, 541, 62 S. Ct. 1110, 1113, 86 L. Ed. 1655 (1942), and '[r]ights far more precious than property rights,' May v. Anderson, 345 U. S. 528, 533, 73 S. Ct. 840, 843, 97 L. Ed. 1221 (1953). 'It is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder.' Prince v. Massachusetts, 321 U. S. 158, 166, 64 S. Ct. 438, 422, 88 L. Ed. 645 (1944). The integrity of the family unit has found protection in the Due Process clause of the Fourteenth Amendment, Meyer v. Nebraska, *supra*, 262 U. S. at 399, 43 S. Ct. at 626, the Equal Protection clause of the Fourteenth Amendment, Skinner v. Oklahoma, *supra*, 316 U. S. at 541, 62 S. Ct. at 1113, and the Ninth Amendment, Griswold v. Connecticut, 381 U. S. 479, 496, 85 S. Ct. 1678, 14 L. Edd 2d 510 (1965) (Goldberg, J., concurring)."



As succinctly stated by this Court in *Wisconsin v. Yoder*, 406 U. S. 205, 232 (1972):

> "The history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children. This primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition."

The recognized right of parents with respect to the upbringing of their children, including provision for care, education, guidance, training and therapeutic treatment for the developmentally disabled comes to the Court deserving of respect. *Amici* are outstanding private institutions designated by certain parents to afford special facilities for the provision of these special services to their children who have special needs. In reaching its decision

the court below overlooked and ignored the long recognized principles of the parent-child relationship designed to assist in the mental development of the child. In addition, the law imposes a duty on parents to care adequately for their children; and the law of nature compels such a duty. The decision below removes from the parents the right and opportunity to freely perform their recognized responsibility to assist their children. Such infringement of the parent's legal rights, therefore, must be carefully scrutinized and presumed to be invalid in order to prevent a split between parent and child which could result in the dissolution of the family unit.

**II. The Decision of the Court Below Unreasonably Interferes With the Right of Parents to Exercise Control Over the Upbringing of Their Minor Children.**

The total adversary proceeding mandated by the elaborate due process procedures required by the District Court ruling unjustifiably and improperly involves the state in the decision-making process of the family with regard to a child's welfare. Legal representation for the child is mandated and cannot be waived. In virtually all cases, the attorney selected to represent the child will be court appointed and paid by the state. The full post-commitment hearing necessitates that the state, through its judiciary, oversee the admission procedure and make the final determination. The state is thus inextricably bound up with, and indeed controls, the parent's right to procure adequate provision for the care and training of their developmentally disabled children. Further, the full adversary proceeding mandated by the court below will inevitably impose upon the family high legal fees. This additional expense to a family already heavily burdened with bills for the care of a child with special problems and



faced with the prospect of continuing expenses for such care is unconscionable. This adversary proceeding, moreover, imposes upon parents and children a conflict which should not exist and can, as is stated in the prior section of this brief, bring about a dissolution of the family unit.

In short, the mandatory involvement of the state in every admission to a mental health or mental retardation facility, whether a private placement or a placement in a state-operated facility, and whether or not the child voices an objection to the admission, spells the end of voluntary admissions and eviscerates the parent's right properly to care for a child. Under the procedures set by the court below, parents must agree to engage in a full adversary proceeding with their own child before securing the opportunity for proper response to the child's needs based upon appropriate professional advice and must necessarily force the parents and child to endure the stigma of a judicial finding by "clear and convincing proof" of mental illness. The modern thinking in this field opposes "labeling". Yet this procedure would require an adjudication which officially labels a child needing special services.

These procedures can only lead to the demise of voluntary admissions to special educational facilities for the mentally ill/mentally retarded or other handicapped children, with a resultant *decline* in the care available to such children, including those children who voice no objection to admission or commitment. Indeed, certain religious groups in Pennsylvania consciously seek to avoid judicial proceedings. In *Eby Estate*, 70 Penna. D. & C. 2d 408 (1975), the Court noted that the religious beliefs of the Mennonites, "one of the plain sects which have been of the fabric of Lancaster County . . . have consistently and determinedly avoided adversary proceedings before the courts." Groups such as these will therefore be unable to

obtain the care required for their children should the guidelines established by the court below be upheld.

No justification exists for imposing such harsh procedural requirements on parents and children. By requiring a hearing to test the propriety of the parental decision to seek admission to a special educational facility, the Court presumes the parental decision to have been improper. This presumption is underscored by the necessity of "clear and convincing proof" to support continued institutionalization. No justification in fact or in law warrants this judicially-created presumption. Are courts to question and presume invalid other parental decisions, such as the decision to send a child to boarding school, merely because some degree of "confinement" is involved? Are hearings to be required before a parent, acting on the advice of physicians, can procure medical or surgical services for their children? There is no challenge to the placement of children with high intelligence quotients in institutions selected by their parents. At what point in the spectrum of intelligence quotients is it necessary or mandatory that parents justify, with "clear and convincing proof," placement of their children with institutions such as *amici*?

*Amici* contend that adequate safeguards can be maintained, and indeed do exist, to prevent the occasional case of alleged misuse of parental responsibility without an all-encompassing presumption of invalidity for all parental decisions. To hold otherwise would shift the burden of highly personal decisions regarding many aspects of a child's life from the family and trained specialists to the impersonal arena of courts, judges and court-appointed attorneys. In Pennsylvania any person, including any licensed physician, nurse or mental health professional, who in the course of his or her employment or practice of his or her profession comes in contact with a child believed



to have been abused *must* report this belief to a state agency. Failure to so report is a summary offense under the Pennsylvania Penal Code. See Child Protective Services Law, P. L. 438, No. 124, §§ 1 *et seq.*, November 26, 1971, 11 P. S. §§ 2201 *et seq.* Thus, the burden of reporting and preventing parental malplacement of children is properly placed on the facility, which is responsible under both the penal and civil laws and ethical professional standards to insure that improper placements are not tolerated. This burden is where it should be, for the facility can utilize its professional expertise to insure against abuse in voluntary admissions, and the strength of the Child Protective Services Law provides adequate protection for the rights of the child. It is respectfully submitted that the existing safeguards adequately protect the interests of the child, parents and the state.

In any event, parents who have an established right and duty to direct the upbringing and the care and education to be provided for their children, and the private facilities selected by them to provide such services, were deprived of the opportunity to be heard. The Opinion and Order below impose unreasonable burdens on parents, and the trauma of a full adversary hearing may well result in irreparable damage to an already mentally ill, disturbed or retarded child, and further deteriorate an already dangerous condition. However, *amici* were not afforded the opportunity to participate in the proceedings or to offer evidence of the adverse effect of these full due process hearings upon available special private services for children who need them and whose parents desire to provide them. For this reason and other reasons hereinbefore mentioned, the action should at the very least be remanded to the court below for the development of a full record by all those directly affected by the result of its decision.

## CONCLUSION.

The total adversary procedure prior to any admission to a facility treating the mentally ill or mentally retarded or developmentally disabled mandated by the court below seriously and unjustifiably interferes with the right, duty and opportunity of parents to procure adequate educational facilities, care and guidance for their children, and should be reversed. At the very least, the private facilities directly affected by the decision of the court below should have been afforded the opportunity to participate in the proceedings and develop a record. Failure to notify *amici* of the pendency of this action irreparably taints the proceedings.

Respectfully submitted,

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MOTION FILED

JUN 4 1976

IN THE

# Supreme Court of the United States

## No. 75-1064

JACK B. KREMENS, Individually and as Hospital Director of Haverford State Hospital; FRANK S. BEAL, Individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; WILLIAM B. BEACH, JR., Individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania, *Appellants*,

*v.*

KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND; Minors, Through Their Next Friend, Individually and on Behalf of All Others Similarly Situated, *Appellees*.

On Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania.

## SPONSORSHIP OF ATTORNEY GENERAL, MOTION FOR LEAVE TO FILE BRIEF, AND BRIEF AMICUS CURIAE FOR THE SUPREME COURT OF PENNSYLVANIA.

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IN THE

# Supreme Court of the United States

—

No. 75-1064

—

JACK B. KREMENS, INDIVIDUALLY AND AS HOSPITAL DIRECTOR OF HAVERFORD STATE HOSPITAL; FRANK S. BEAL, INDIVIDUALLY AND AS SECRETARY OF PUBLIC WELFARE OF THE COMMONWEALTH OF PENNSYLVANIA; WILLIAM B. BEACH, JR., INDIVIDUALLY AND AS DEPUTY SECRETARY FOR MENTAL HEALTH AND MENTAL RETARDATION OF THE DEPARTMENT OF PUBLIC WELFARE OF THE COMMONWEALTH OF PENNSYLVANIA,

*Appellants,*

*v.*

KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND; MINORS, THROUGH THEIR NEXT FRIEND, INDIVIDUALLY AND ON BEHALF OF ALL OTHERS SIMILARLY SITUATED,

*Appellees.*

—

ON APPEAL FROM THE JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA.

———

The action in which the Supreme Court of Pennsylvania here seeks to appear and present its views *amicus curiae*, was brought on behalf of a class of juveniles, arguing that before members of plaintiff class could be committed to hospitals by their parents for care or treatment, they were constitutionally entitled to a hearing held in accordance with due process requirements. The lower court upheld and elaborated in some detail on plaintiffs'

constitutional entitlement to a counseled hearing before a neutral tribunal.

Although it conceded that the Commonwealth had no constitutional duty to provide a judicial or court hearing, the lower court imposed upon the courts of the Commonwealth the obligation to provide hearings—both prospectively and, within 120 days, to all members of plaintiff class presently hospitalized without benefit of a hearing. Thus, the Pennsylvania judiciary was ordered to provide relief although the Constitution did not require it to do so and although neither it, nor the Commonwealth itself as opposed to several of its executive officers, was a party to or had had representation in the proceedings before the court.

It would be inappropriate for the Pennsylvania Supreme Court to take a position on the merits of this case, *i.e.*, whether pre-commitment hearings of any sort are constitutionally required. However, in view of the fact that the lower court has ordered the Pennsylvania courts to provide the relief prescribed, the Pennsylvania Supreme Court is at least entitled to the opportunity to be heard on this question.[1] Accordingly, the Supreme Court of Pennsylvania submits the following statement of sponsorship by the Attorney General which, pursuant to Rule 42(4) of the Rules of this Court, satisfies the preconditions for filing the attached brief *amicus curiae*, despite the fact that counsel for appellees has refused to consent to this filing.

---

1. It is believed that the Pennsylvania Supreme Court has a right to intervene. See **United States v. Terminal Railroad Association**, 236 U. S. 194, 199 (1915); *cf.* **Hunter v. Ohio ex rel. Miller**, 396 U. S. 879 (1969); **United States v. Paramount Pictures, Inc.**, 334 U. S. 131, 176-78 (1948). Since intervention is unusual, however, and rarely if ever uncontested, and in view of the fact that the Attorney General of Pennsylvania has agreed to provide sponsorship, the Pennsylvania Supreme Court has chosen to follow the more traditional route of appearing as *amicus curiae*.



## SPONSORSHIP OF THE ATTORNEY GENERAL OF PENNSYLVANIA.

Under Article 5 of the Pennsylvania Constitution, the Pennsylvania courts, like the Article III Courts of the United States, constitute one branch of the tripartite government of the Commonwealth. As such, they are as much the Commonwealth as are the legislative and executive branches, and equally as entitled to appear as *amicus curiae* before this Court, even though opposing counsel would prefer that they did not. Nor does the Supreme Court of Pennsylvania become any less the Commonwealth for purposes of presenting a unique interest under Rule 42(4) simply because certain executive officers of Pennsylvania are the named appellants and are represented, as required by statute, by the Attorney General.

The interest sought to be asserted by the Pennsylvania courts is different than that of the Commonwealth generally and must be separately represented. First, this Office has declined to represent the judiciary as an independent branch of government on Constitutional grounds of separation of powers, *see* Attorney General's Opinion No. 75-9, Pennsylvania Bulletin, Vol. 5, No. 10 (March 8, 1975). Second, the named defendants are appealing the decision on the merits and are also challenging the legality of the relief ordered. The interest of the Pennsylvania courts focuses exclusively on the latter issue. It is altogether appropriate that the distinct interest of the Pennsylvania Supreme Court be heard in this latter issue.

Therefore, being charged with the duty of representing the named defendants in this case and recognizing the substantiality of the issues which the Pennsylvania judiciary would put before this Court, this Office undertakes to sponsor pursuant to Rule 42(4), and urges this Court to

afford hearing as *amicus curiae* to, the Supreme Court of Pennsylvania.

/s/ ROBERT P. KANE,
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*Commonwealth of Pennsylvania.*



## ALTERNATE MOTION FOR LEAVE TO FILE BRIEF ON BEHALF OF THE SUPREME COURT OF PENNSYLVANIA, *AMICUS CURIAE.*

Alternatively, if the above statement of sponsorship should in any way fail to qualify the Pennsylvania Supreme Court to appear as *amicus curiae* under Rule 42(4), then, pursuant to Rules 35 and 42 of the Rules of the Court, the Supreme Court of Pennsylvania respectfully moves this Court for leave to file the attached brief *amicus curiae*, and in support thereof, states the following:

1. The Pennsylvania Supreme Court is the highest court in the Commonwealth and is charged by the Constitution of the Commonwealth with general supervisory and administrative authority and empowered to prescribe general rules governing practice, procedure and the conduct of the Pennsylvania courts. Pennsylvania Constitution, Article 5, Sections 1, 10. It is, therefore, the proper party to protest both the burden and the affront implicit in a lower federal court's imposing on the Pennsylvania judiciary the duty of both prospective and retrospective implementation of the prescribed hearing procedures pending creation by the legislature of an alternative non-judicial tribunal, which is all that the lower court has held that the Constitution requires.

2. In his December 1, telegram joining the Commonwealth in its request for a stay, Chief Justice Benjamin R. Jones of the Pennsylvania Supreme Court informed this Court that the estimated six to eight thousand recommitment hearings ordered to be held by the Pennsylvania judiciary within the next 120 days [2] would result in ". . .

2. In the telegram it was inadvertently stated that five months, rather than four, were to be permitted the Pennsylvania courts to comply with the order of the court below. The time prescribed is, of course, four months.

overwhelming and disrupting the judicial systems of Pennsylvania which are already overburdened with regular court business."

Of longer-range significance, however, is the fact that, in imposing upon the courts of the Commonwealth a procedure which the Constitution does not require to be judicially provided, the lower court utterly ignored the principles of comity and mutual respect which this Court has repeatedly held to be necessary to the proper functioning of our federal system. The lower court's manifest disregard for the sovereign status of a parallel state court system is underlined by the fact that neither the Pennsylvania Supreme Court nor any other unit of the Pennsylvania judicial system was even a party to the litigation before the lower court.

3. While the interests sought to be vindicated by the Pennsylvania Supreme Court are of vital importance to the Commonwealth generally, they are distinct from and more appropriately asserted separately from the interests of the named executive officers in this appeal. Thus, the Attorney General has declared himself constitutionally barred from representing the state judiciary, Attorney General's Opinion No. 75-9, Pennsylvania Bulletin, Vol. 5, No. 10 (March 8, 1975).

4. As soon as the jurisdictional statement was prepared, the Pennsylvania Supreme Court requested the parties herein to give their consent to its filing a brief as *amicus curiae*. Counsel for appellants gave immediate consent. At that time, counsel for appellees expressed the belief that the request was premature; however, when on May 3, 1976, he refused consent, he declined to state why he had agreed to all requests to file briefs *amicus* except the request of the Pennsylvania Supreme Court. It is in the belief that this Court needs to have the benefit of the views



of the Pennsylvania Supreme Court, that this Court is respectfully urged to accept the attached brief *amicus curiae*.

WHEREFORE, the Pennsylvania Supreme Court requests this Court to grant it leave to file the brief *amicus curiae* annexed hereto by virtue of the sponsorship of the Attorney General of Pennsylvania under Rule 42(4), or if by any chance the Court should deem such sponsorship insufficient, then on the Alternate Motion of the Supreme Court of Pennsylvania on behalf of the judicial system of the Commonwealth.

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Dated: June 4, 1976.

IN THE

# Supreme Court of the United States

No. 75-1064.

JACK B. KREMENS, INDIVIDUALLY AND AS HOSPITAL DIRECTOR OF HAVERFORD STATE HOSPITAL; FRANK S. BEAL, INDIVIDUALLY AND AS SECRETARY OF PUBLIC WELFARE OF THE COMMONWEALTH OF PENNSYLVANIA; WILLIAM B. BEACH, JR., INDIVIDUALLY AND AS DEPUTY SECRETARY FOR MENTAL HEALTH AND MENTAL RETARDATION OF THE DEPARTMENT OF PUBLIC WELFARE OF THE COMMONWEALTH OF PENNSYLVANIA,

*Appellants,*

*v.*

KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND; MINORS, THROUGH THEIR NEXT FRIEND, INDIVIDUALLY AND ON BEHALF OF ALL OTHERS SIMILARLY SITUATED,

*Appellees.*

ON APPEAL FROM THE JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA.

## BRIEF FOR THE SUPREME COURT OF PENNSYLVANIA, *AMICUS CURIAE.*

### I. INTEREST OF *AMICUS CURIAE.*

This appeal presents two questions: the first is whether and to what extent the Constitution requires that juveniles not be committed to hospitals by their parents for care or

treatment without a counselled adversary hearing; the second is whether a United States District Court may order that a state court system provide the hearings in such cases even though that court has held that the Constitution requires only that hearings be provided before some neutral tribunal. One added factor is that none of the Pennsylvania courts was party to the action in the lower court.

The first issue was posed by plaintiffs' complaint in the court below. However, in ordering relief, that court went beyond its finding that due process demands that the state provide hearings before a neutral tribunal and required that the prescribed hearings be provided, in fact, by the Pennsylvania courts. It is only with respect to this second issue that the Pennsylvania Supreme Court wishes to be heard as *amicus* in opposing the order of the lower court.

The Supreme Court of Pennsylvania is responsible, both symbolically and literally, for the judicial branch of government in Pennsylvania. It is the highest court in the Commonwealth; in addition, since the creation of a unitary court system in 1968, it is constitutionally charged with general supervisory and administrative authority and empowered to prescribe general rules governing practice, procedure and the conduct of the Pennsylvania courts. Pennsylvania Constitution, Article 5, sections 1, 10.

Thus, the Pennsylvania Supreme Court actually has more than an *amicus* interest in this case, but is, in fact, directly adversely affected by the order appealed from insofar as it imposes on the Pennsylvania court system the burden of both prospective and retrospective implementation of the prescribed hearing procedures unless and until creation by the legislature of some alternate tribunal.[1]

1. As indicated in the telegram sent by Chief Justice Benjamin R. Jones to this Court, joining the Commonwealth in its request for a stay, the court had originally contemplated formal intervention in this action. While such an option would appear to be available



As a practical matter, the Pennsylvania court system simply does not have the resources or facilities to provide an estimated six to eight thousand recommitment hearings within the required 120 days without severely compromising its capacity otherwise to see to the administration of justice in Pennsylvania.

Of broader significance, however, is the affront such an order offers to those basic principles of federalism which, where there are constitutionally permissible alternatives, restrain a federal court from imposing obligations upon an independent state court system which is not even a party to the proceedings before it.

The interest thus sought to be asserted by the Pennsylvania Supreme Court is not simply that of the Commonwealth generally; and this is particularly so since the burden imposed upon the Pennsylvania judiciary came as the price of deference which the court below chose to extend to the legislative branch of the state government.

1. (Cont'd.)
under the circumstances, the court decided to proceed as expeditiously as possible by following the more usual route of filing this brief, *amicus curiae*, particularly in view of the sponsorship of the Attorney General of Pennsylvania under Rule 42(4).

## II. ARGUMENT.

It is basic to that unity of philosophical and political principles which this Court has recently referred to as "Our Federalism,"[2] that except where the Constitution permits no alternative, a federal court may not exercise its equity power in a manner which would interfere with a state's control of its internal governance. Moreover, such considerations of comity have been followed by this Court with particular care as regards the deference to be accorded a state judicial system by its federal counterpart. The balance between federal and state power which has been thus deliberately and thoughtfully developed is destroyed when a federal court feels free not only to dictate to a state the manner in which it is to discharge its constitutional obligations, but to require (without constitutional necessity) an independent state court system to carry out its orders.

### A. A Federal Court May Not Enjoin a State To Take Action Which Is Not Constitutionally Required.

The idea that the task of providing preliminary and final commitment hearings should be assigned to the courts of Pennsylvania arrived late in the proceedings below. The original complaint sought no more than a "disinterested and impartial decision maker" (14a).[3] The court in its opinion found the need for no more than an "unbiased tribunal" (40a). The idea of requiring the Pennsylvania courts to provide a forum for these hearings "until the legislature acts" appeared for the first time in plaintiffs' proposed order (66a). Despite the facts that plaintiffs' counsel had never argued that a court hearing was required, that the Attorney General submitted a proposed order which gave clear indication of the burden which would be placed on the Pennsylvania courts by plaintiffs' proposed order (74a-75a), that the Pennsylvania courts were not a party to the proceedings, and that the court below not only did not find a need for court hearings, but specifically recognized the power in the legislature to establish "an alternate neutral tribunal to conduct the probable cause and full commitment hearings," (80a) the court adopted plaintiffs' proposal and "declared that the present facilities of the Commonwealth system be used for these hearings" (*id*). The Attorney General took appropriate exceptions, noting that the paragraph of the court's order in question

> ". . . designates the Commonwealth Court system as the judicial system for the probable cause and full commitment hearings. This Court is thus creating a cause of action in a separate judicial system without a present legislative or common law foundation. . . . It is unclear and a matter of substantial controversy whether a Federal District Court has the authority under the Constitution of the United States or any Act of Congress to exercise such direction and control over the Commonwealth's judicial branch of government and its judicial officers."

(90a-91a). Nevertheless, the court below persisted in using the language originally proposed by plaintiffs and adopted in the court's proposed order. See 100a. In so doing, the court below interfered with the most basic constitutional decision of the Commonwealth of Pennsylvania: the allocation of powers and duties among the executive, judicial and legislative branches of government. And it did so at a hearing at which neither the judicial nor the

2. **Younger v. Harris**, 401 U. S. 37, 44 (1971).

3. References to "a" pages are to the Appendix to the Jurisdictional Statement.

legislative branches of government nor any officers or agents of either was a party.[4]

The issue here is not whether the plaintiffs are entitled to relief, but whether they are entitled to the relief granted them in derogation of the legitimate interests of the courts of Pennsylvania.

The constitutional basis on which the court below struck down portions of Pennsylvania's Mental Health and Mental Retardation Act ("The Act"),[5] was that a juvenile committed to a mental institution is entitled, *inter alia*, to a hearing before a neutral tribunal. However, when the court went on to order that unless or until the state legislature should constitute such a neutral tribunal, hearings must be provided in fact by the Commonwealth court system, and that these hearings must be provided not only for juveniles committed in the future, but for every juvenile presently incarcerated pursuant to the invalidated provisions of the Mental Health Act (100a, 105a), it went beyond any constitutional mandate.

Such an order is wholly unmindful of those essential principles of federalism which this Court has held must control the availability and scope of federal equitable relief in "a system of federal courts representing the Nation,

4. After the court below had written its proposed order, the office of the Court Administrator of Pennsylvania became aware of the existence of the decision of the court and was given permission to make proposals with respect to the drafting of the final order concerning the question of how the Pennsylvania courts would deal with the "large potential hearing responsibility which the decision places upon our state trial system." Letter, Jonathan Vipond, III, Legal Assistant to the Court Administrator of Pennsylvania, to the Honorable Daniel H. Huyett, III, dated October 15, 1975. Plainly, Mr. Vipond believed that he had been invited not to participate in the decision of whether the state courts were to be forced to conduct hearings, but only to aid in suggesting how the state courts would best carry out the duty imposed upon them by the federal court below.

5. The relevant portions of the Act are quoted in full at pp. 4-5 of the Jurisdictional Statement.



subsisting side by side with 50 state judicial, legislative and executive branches . . .". **Rizzo v. Goode,** 44 U. S. L. W. 4095, 4100 (U. S. Jan. 21, 1976).

Whether or not the court below acted properly when it found the Pennsylvania juvenile commitment procedure lacking in due process and enjoined its enforcement, that court had no authority to impose upon the Commonwealth —specifically the courts of the Commonwealth—an alternative procedure which, however salubrious, is not constitutionally required.

This is precisely the teaching of this Court's decision in **Gerstein v. Pugh,** 420 U. S. 103 (1975), a class action brought under 42 U. S. C. § 1983 to challenge the adequacy of Florida's pre-trial detention procedures. There, as here, the lower court had merely declared a constitutional right to a predetention probable cause determination, but had set up detailed procedures for an adversary hearing to implement that right. There, this Court concluded that the procedures—in contrast to the right they sought to protect—were not constitutionally required, and the lower court's opinion and order here make it equally clear that the Constitution does not require the state court hearings which the lower court, nevertheless, ordered. There, this Court held that it was improper for the lower courts to impose upon the state court system procedures not required by the Constitution. The same conclusion is appropriate here.

In leaving the state and its courts free to create whatever procedures they might find appropriate within the constitutional framework, this Court stated (420 U. S. at 123):

> "Although we conclude that the Constitution does not require an adversary determination of probable cause, we recognize that state systems of criminal

> procedure vary widely. There is no single preferred pretrial procedure, and the nature of the probable cause determination usually will be shaped to accord with a State's pretrial procedure viewed as a whole. While we limit our holding to the precise requirement of the Fourth Amendment, we recognize the desirability of flexibility and experimentation by the States."

The court below showed no such respect for the Pennsylvania courts, although it did recognize the right of the legislature, should it choose, to create alternative procedures. But, by placing the burden on the state courts to provide hearing so long as the legislature did not develop an alternative neutral tribunal, the court removed all pressure on the legislature to develop such alternative procedures.

The court below had no power to require the Pennsylvania courts to conduct commitment hearings when the Constitution, by its own admission, did not require a court hearing. Certainly it had no right to limit the courts to the use of their present facilities when, again by its own admission, the Constitution would be satisfied by the appointment of unbiased masters to conduct neutral hearings. The only question which the court below should have reached under this Court's decision in **Gerstein** is whether the Constitution required the relief which the court sought to grant; otherwise, the court had no power to interfere with the state's freedom to allocate the hearings to any constitutionally satisfactory body. See 420 U. S. at 125-26, n. 27; *see also* **Hague v. C. I. O.,** 307 U. S. 496, 518 (1939).

Even more recently in **Rizzo v. Goode,** *supra,* this Court made clear that a federal court may not enjoin a state to adopt merely prophylactic procedures. Thus, in the absence of a constitutional right to citizens' grievance procedures, the Court held that the district court's attempt



to impose such procedures upon the Philadelphia Police Department via injunctive decree ran sharply counter to "'the well-established rule that the Government has traditionally been granted the widest latitude in the 'dispatch of its own internal affairs,' [citations omitted].'" 44 U. S. L. W. at 4100.[6]

Thus, there was every reason for the court below to defer to the principles of comity which would have left to the government of Pennsylvania—including the Pennsylvania courts—the freedom to develop a constitutionally permissible hearing procedure. The court below, itself, had recognized that there are constitutionally permissible alternatives to conducting preliminary and final commitment hearings, as well as some six to eight thousand recommit-

6. There are only two classes of cases which are exceptions to the general rule that a federal court will not attempt to dictate state procedures.

The first class of cases are those where, having been given ample opportunity to develop constitutionally adequate procedures, a state has refused to comply with an announced constitutional requirement. Thus, for example, federal courts have been held to have power to fashion specific orders in reapportionment and school desegregation cases after the states have defaulted in their obligation to proffer acceptable remedies. See *e.g.,* **Reynolds v. Sims,** 377 U. S. 533, 586 (1964); **Swann v. Charlotte-Mecklenberg Board of Education,** 402 U. S. 1, 16 (1971); **Griffen v. County School Board,** 377 U. S. 218, 233-234 (1964). In such cases, a federally defined remedy becomes the only means of vindicating the constitutional rights in question.

Similarly, where the Constitution, itself, prescribes the appropriate procedure for vindication of the right involved, a federal court has no alternative but to require the states to comply with that procedure. Thus, in **Gideon v. Wainwright,** 372 U. S. 335 (1963) (right to counsel in criminal prosecution), and **In re Gault,** 387 U. S. 1 (1967) (right to counselled adversary hearing in delinquency proceedings), the criminal context left no room under the Constitution for any solution other than the provision of judicial hearings. On the other hand, this Court specifically noted in **Goldberg v. Kelly,** 397 U. S. 254 (1970), with respect to the requirement of a hearing prior to the termination of welfare benefits that "the pre-termination hearing need not take the form of a judicial or quasi-judicial trial." *Id.* at 266.

ment hearings in the Pennsylvania courts. See, *e.g.*, 39a-41a, 80a, 100a. Nor has the Commonwealth given the federal courts any reason to believe that it will not act with due speed and care to provide such a constitutional alternative; on the contrary, even after the institution of this action, the Department of Public Welfare acted on its own initiative to adopt new regulations which at least partially cured the alleged constitutional infirmities of the Act. See 25a-27a. Finally, the lower court clearly could have afforded the Commonwealth a proper opportunity to comply with its order without causing irreparable harm to any member of the appellee class who believes himself improperly committed since an action in habeas corpus is statutorily authorized and available here to provide full and adequate relief.[7]

Under such circumstances the federal district court had no power to upset the " 'special delicacy of the adjustment to be preserved between federal equitable power and State administration of its own law.' [citations omitted]," which dictated judicial forbearance in this case. **Rizzo v. Goode,** *supra*, 44 U. S. L. W. at 4100.

7. Section 426 of the Mental Health and Mental Retardation Act of 1966, Act of October 20, 1966, Special Sess. No. 3, P. L. 96, 50 P. S. § 4426, provides that any person committed or detained pursuant to that act may petition for a writ of habeas corpus based upon, *inter alia*, "the insufficiency or illegality of the proceedings leading to such person's commitment . . ."

Appellants have argued that under this Court's decision in **Preiser v. Rodriguez,** 411 U. S. 475 (1973), the remedy at § 426 is exclusive and precludes any retroactive application of the injunctive relief ordered below. Jurisdictional Statement, pp. 15-18. Without expressing a position on the merits, at least it is clear that the remedy provided at § 426 obviates any claim that irreparable injury would result were Pennsylvania afforded the normal deference due a sovereign state by a federal district court.



**B. Federal Equity Power Is Most Severely Limited Where It Would Have the Effect of Interfering With a Parallel State Court System.**

As this Court said in **Rizzo v. Goode,** *supra,* the principles of federalism which govern generally the relationship between federal courts and state governments were "initially expounded and perhaps entitled to their greatest weight" in cases where injunctive relief was sought against the judicial branch of state government. 44 U. S. L. W. at 4101. Given this history, the deference which the lower court chose to show the legislature of Pennsylvania at the expense of the court system of Pennsylvania is totally inexplicable.

In **Younger v. Harris,** 401 U. S. 37 (1971), this Court initially announced a carefully limited rule that, barring extraordinary circumstances, a federal court will not enjoin state criminal proceedings. The decision was an example of the principle that a court of equity should not act when there is an adequate remedy at law,[8] which principle "is reinforced by an even more vital consideration" which the Court described as (401 U. S. at 44):

> "• • • the notion of 'comity', that is, a proper respect for state functions, a recognition of the fact that the entire country is made up of a Union of separate state governments, and a continuance of the belief that the National Government will fare best if the States and their institutions are left free to perform their separate functions in their separate ways."

As subsequent cases made clear, it is this notion of comity which really underlies the decision in **Younger,** and

8. As indicated, *supra,* there is no question here that there is an adequate remedy at law, at least for those appellees already institutionalized, since § 426 of the Act gives them a right to petition for habeas corpus relief.

the **Younger** rule of judicial forbearance has not been limited to pending state criminal proceedings, but has been broadly applied wherever federal intervention would have the effect of interfering with and undermining the independence of a state judiciary to carry out its own proceedings. *See, e.g.*, **Huffman v. Pursue, Ltd.**, 420 U. S. 592 (1975) (applying **Younger** to include certain civil proceedings and to require exhaustion of state appeal procedures); **O'Shea v. Littleton,** 414 U. S. 488 (1974) (applying **Younger** in absence of pending state proceedings to preclude federal intervention which would establish basis for collateral attack on future state proceedings); *cf.* **Rizzo v. Goode,** *supra,* (applying policy of **Younger** line of cases to preclude injunctive relief against local, non-judicial, government agency).

Of particular relevance to the case at bar is this Court's determination in **O'Shea v. Littleton,** *supra,* that the principles of federalism and comity found controlling in **Younger** are equally applicable when a federal court attempts to oversee or regulate *future* state court proceedings. In **O'Shea,** suit had been brought for injunctive relief against a county magistrate and a judge alleging patterns of discrimination against black citizens with respect to the setting of bonds, sentencing, and the availability of jury trials in criminal cases. Reversing the district court's dismissal on grounds of judicial immunity and its own lack of jurisdiction to issue the injunctive relief prayed for, the Court of Appeals held that if the allegations were proved, the district court would be able to fashion appropriate injunctive relief. This Court reversed, holding, *inter alia,* that ". . . even if we were inclined to consider the complaint as presenting an existing case or controversy ****'the principles of equity, comity and federalism that must restrain a federal court when asked to enjoin a state



court proceeding' [citation omitted] . . . preclude equitable intervention in the circumstances present here." 414 U. S. at 499.

The Court reasoned that the equitable decree approved in theory by the Court of Appeals would, in effect, simply establish the basis for federal intervention in future state court proceedings to adjudicate allegations of non-compliance with the federal decree. "This," said the Court, "seems to us nothing more than an ongoing federal audit of state criminal proceedings which would indirectly accomplish the kind of interference that **Younger v. Harris,** *supra,* and related cases sought to prevent." 414 U. S. at 500. *See* **Gardner v. Luckey,** 500 F. 2d 712 (5th Cir. 1974) (relying on **O'Shea** to deny relief upon plea for court-ordered reform of state public defender offices).

The abstention principle developed in the **Younger** line of cases was relied upon by the Court of Appeals for the Second Circuit in **Wallace v. Kern,** 520 F. 2d 400 (2d Cir. 1975), to invalidate an injunctive decree comparable to that in the instant case, which purported to remedy constitutionally defective bail procedures by ordering the courts of Kings County, New York, to implement a series of new procedures, including the provision of pre-trial evidentiary bail hearings on demand. The Court rejected the argument that **Younger** is limited to cases where a federal court seeks to enjoin a pending criminal prosecution, but reiterated its own prior holding that " 'under the principle known as comity a federal district court has no power to intervene in the internal procedures of the state courts." [9] (520 F. 2d at 405).

9. The court here quoted from its per curiam order in one of two earlier appeals in the **Wallace** case in which it reversed a preliminary injunction ordering court personnel to place certain *pro se* motions on the court's calendar. **Wallace v. Kern,** 481 F. 2d

While expressing sympathy with the lower court's objectives, the **Wallace** court warned that reform of the state penal system was not the responsibility of federal courts. And it specifically rejected the argument that the intrusion into state affairs was not substantial, stating at p. 408:

> "Here, the federal court did not invite state officials to submit a plan for a bail hearing which would be consistent with due process requirements. It rather directed its own procedures for state hearings in considerable detail. This constitutes, in our view, federal judicial legislation. . . ."

The magnitude of the intrusion in the present case is even greater than in **Wallace.** Here, the lower court did not simply interfere with the power of the state courts to create appropriate rules for matters within their jurisdiction, but actually undermined the state's constitutional balance between the judicial and legislative branches by assigning cases to the court system without any constitutional requirement that they be so assigned.

There is the very clearest and most direct clash of federal and state authority when a federal court attempts to regulate the procedures of a state court system. Considerations such as these led the Court of Appeals for the First Circuit in **Ad Hoc Committee on Judicial Administration v. Commonwealth of Massachusetts,** 488 F. 2d 1241 (1st Cir. 1973), *cert. denied* 416 U. S. 986 (1974), to declare simply non-justifiable a complaint in a federal court alleging that delay in the Massachusetts court system constituted a denial of due process and praying the federal court to order and oversee implementation of appropriate reform programs. The conclusion reached in **Ad Hoc Committee** in response to a direct request to impose federal regulation upon a state court system is no less applicable when the same result is achieved indirectly; ". . . it would be both unprecedented and unseemly for a federal judge to attempt a reordering of state priorities." 488 F. 2d at 1245-46. *See* **Gardner v. Luckey,** *supra,* 500 F. 2d at 715; **Inmates of Attica Correctional Facility v. Rockefeller,** 477 F. 2d 375, 382-383 (2d Cir. 1973) (judicial incapacity to enforce state duty to investigate and prosecute those connected with prison rioting).

9. (Cont'd.)
621 (2d Cir. 1973), *cert. denied* 414 U. S. 1135 (1974). In a second interlocutory appeal at 499 F. 2d 1345, *cert. denied* 420 U. S. 947 (1975), the court had invalidated a preliminary injunction ordering the release of all prisoners not brought to trial on demand within a specified time period. The court there held that, as a constitutional matter, the requirement of a "speedy trial" must be evaluated on a case-by-case basis, and that in the absence of a constitutional foundation for its order, "[t]his is not the proper business of the federal courts, which have no supervisory authority over the state courts and have no power to establish rules of practice for the state courts." 499 F. 2d at 1351.



### C. The Mere Fact That a Federal Court Has Jurisdiction Over Certain Executive Officers Does Not Give That Court Power Over the State Judicial System, None of Whose Officers Is Before It.

The present case was brought against three named officers of the Executive Department of the Commonwealth of Pennsylvania. No attempt was made to join any representative of the courts of Pennsylvania in the suit, and, indeed, there was no reason to believe that the Pennsylvania courts would be involved in any relief that was granted in this case. Nevertheless, when plaintiffs drew up their proposed order, they sought to impose duties upon the Pennsylvania courts for an indeterminate period of time, and the court below adopted plaintiffs' proposal.

Because the Eleventh Amendment prohibits individuals from suing a state in the federal courts, suits such as

this one are brought against the state officers whose conduct a plaintiff may wish to enjoin. See **Ex parte Young,** 209 U. S. 123 (1908). Because the state cannot be named a party in a suit such as the one presently before the Court, a federal court cannot enjoin state action generally, but is limited in framing an injunctive order to enjoining the future conduct of the state officers named as parties defendant in the action before it. **Edelman v. Jordan,** 415 U. S. 651 (1974).

Certainly the executive officers named as parties defendant in this litigation in no way control the Pennsylvania judicial system, and the fact that the court below had the power to enjoin the activities of the executive departments involved through the presence of their officers as parties defendant gave the court no power over the Pennsylvania courts. For, in gauging the extent of their equity power in a given case, the federal courts cannot make their injunctions run beyond the scope of the lawful authority of the defendant officers under state law.

In **Wyatt v. Aderholt,** 503 F. 2d 1305 (5th Cir. 1974), suit was brought against the Governor and certain Alabama officials responsible for the state's mental health programs to declare a constitutional right to treatment and implement appropriate standards. Since the Governor had stipulated to minimum standards required by the Constitution, the Court of Appeals did not have to consider whether such standards were, in fact, required or "whether it is within the province of a federal district court, three-judge or single judge, to prescribe standards as distinguished from enjoining the operation of such institutions while constitutional rights are being violated." 503 F. 2d at 1317. On the other hand, the court held that the stipulated standards were binding only on the Governor, the legislature not having been joined as a party defendant. The court continued (*id*):



"Governor Wallace contends such stipulations are not binding on him or the Alabama legislature. As a party to the stipulations, through counsel, we hold the Governor has for his part agreed that these standards are minimally acceptable under the Constitution. The Alabama legislature presents a different problem. Clearly the Governor is without authority to agree to the expenditure of funds required to implement such a broad spectrum of standards when such a decision under Alabama law is reserved to the legislature. That the legislature was not a party to the stipulations in question or to this law suit reenforces this manifest principle of governmental organization. It is the Governor's role to propose relief to the legislature and having stipulated the standards, to use his best efforts to accomplish the relief."

Again in **Norris v. State Council of Higher Education,** 327 F. Supp. 1368 (E. D. Va. 1971), *aff'd per curiam* 404 U. S. 907 (1971), the court refused to order the defendant Governor or the State Council of Higher Education to prepare a plan for desegregation of the state colleges since, under state law, each institution was controlled by its board of visitors so that "the persons necessary for adjudicating this phase of the case have not been sued," *id.* at 1373.

Similarly, in the instant case, no party before the lower court has authority to impose procedures upon the state court system; that authority has been delegated by the Pennsylvania Constitution to the Pennsylvania Supreme Court. Pennsylvania Constitution, Article 5, Section 10(c).[10]

10. The allocation of responsibilities among the three branches of government is made by the people through the state constitution or by the legislature, subject to executive veto and judicial review.

## III. CONCLUSION.

The district court was not unconscious of the fundamental issues of federalism involved in this case. It stated (39a, n. 16):

> ". . . We are aware of the problems facing courts when they attempt to fashion procedures protecting interests within the liberty and property language of the Fourteenth Amendment and we are sensitive to the claim that courts are 'good at defending cases, bad at drafting legislation . . .'
> . . . Our action is not intended to pre-empt the state which is free to develop its own safeguards so long as they are as fully effective as these which we set out . . ."

Nonetheless, while the Court did, in fact, afford the *legislature* an opportunity to constitute a neutral tribunal in accordance with its decree, it did not hesitate to order the judiciary—immediately, and until such time, if ever, as the legislature should act—to provide the prescribed hearings, not only to all juveniles committed in the future but, within 120 days, to all juveniles presently incarcerated pursuant to the invalid legislation. This was despite the fact that the procedural apparatus thus fastened upon the state court system was conceded by the court below not to be required by the federal Constitution; and the Pennsylvania Supreme Court was not even a party to the proceedings below.

Such callous intervention by a federal court into the internal affairs of a sovereign state government, particularly its court system, and all the more when the Supreme Court was not a party to the proceeding, is completely at odds with established principles of federalism and comity.



*Wherefore*, the Pennsylvania Supreme Court as *amicus curiae* respectfully requests that if this Court does not reverse the order of the court below in its entirety, at the very least the order be modified to the extent that it imposes any duty upon the courts of the Commonwealth of Pennsylvania.

Respectfully submitted,

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Dated: June 4, 1976.

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IN THE SUPREME COURT OF THE UNITED STATES

No. 75-1064

JACK B. KREMENS, Individually and as Hospital Director of Haverford State Hospital; FRANK BEAL, Individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; WILLIAM B. BEACH, JR., Individually and as Deputy Secretary of Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,

Appellants

v.

KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND, Minors, Through Their Next Friend, Individually and on Behalf of All Others Similarly Situated,

Appellees

On Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania

RESPONSE TO PETITION OF SUPREME COURT OF PENNSYLVANIA FOR RECONSIDERATION OF THIS COURT'S DENIAL OF LEAVE TO FILE BRIEF AMICUS CURIAE

1. The Court properly denied leave to the Supreme Court of Pennsylvania to file a brief amicus curiae in this matter. The petitioner's motion for reconsideration contains no new grounds, facts or intervening circumstances in support of its request.

2. The Supreme Court of Pennsylvania again seeks leave to file a brief, describing itself as speaking "only in its constitutionally mandated position

10

as supervisor and administrator of Pennsylvania's unified judicial system," Petition at 2, citing Article V, Section 10 of the Pennsylvania Constitution (reproduced at Appendix A of Petition). That constitutional provision, however, confers no authority on the Pennsylvania Supreme Court to speak for all state courts, make policy decisions for them or to participate in any manner in any litigation.

3. The interests of the Pennsylvania courts are fully and competently represented by the Attorney General of Pennsylvania whose brief argues and supports without qualification the very claims sought to be raised by the proposed amicus brief.

4. Permitting the filing of an amicus brief by a state's high court would establish a precedent for similar action whenever any court in the nation desires to comment on an issue before this Court.

5. Rule 42(4) provides no support for the filing of this amicus brief. The Supreme Court of Pennsylvania is neither a "State, Territory or Commonwealth" nor a "political subdivision" thereof.

6. Neither the rules of this Court nor the interests of justice warrant a reconsideration of this Court's decision in this matter.

WHEREFORE, it is respectfully submitted that the petition for reconsideration should be denied.

Respectfully submitted,

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Counsel for Appellees

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Philadelphia, Pa. 19103

Supreme Court, U. S.
FILED
JUL 16 1976
MICHAEL RODAK, JR., CLERK

IN THE

# Supreme Court of the United States

## No. 75-1064.

JACK B. KREMENS, Individually and as Hospital Director of Haverford State Hospital; FRANK S. BEAL, Individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; WILLIAM B. BEACH, JR., Individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania, *Appellants,*

*v.*

KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND; Minors, Through Their Next Friend, Individually and on Behalf of All Others Similarly Situated, *Appellees.*

On Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania.

## PETITION OF THE SUPREME COURT OF PENNSYLVANIA, IN ITS ADMINISTRATIVE ROLE FOR THE UNIFIED PENNSYLVANIA JUDICIAL SYSTEM, AND OF THE ATTORNEY GENERAL OF PENNSYLVANIA, AS SPONSOR, FOR RECONSIDERATION OF DENIAL OF LEAVE TO FILE BRIEF AMICUS CURIAE BY THE SUPREME COURT OF PENNSYLVANIA.

ROBERT P. KANE,
Attorney General of the Commonwealth of Pennsylvania,
*Sponsor of the Brief of the Supreme Court of Pennsylvania as Amicus Curiae.*

BERNARD G. SEGAL,
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International Printing Co., 711 So. 50th St., Phila., Pa. 19143 — Tel. (215) 727-8711

IN THE

# Supreme Court of the United States

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No. 75-1064.

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JACK B. KREMENS, INDIVIDUALLY AND AS HOSPITAL DIRECTOR OF HAVERFORD STATE HOSPITAL; FRANK S. BEAL, INDIVIDUALLY AND AS SECRETARY OF PUBLIC WELFARE OF THE COMMONWEALTH OF PENNSYLVANIA; WILLIAM B. BEACH, JR., INDIVIDUALLY AND AS DEPUTY SECRETARY FOR MENTAL HEALTH AND MENTAL RETARDATION OF THE DEPARTMENT OF PUBLIC WELFARE OF THE COMMONWEALTH OF PENNSYLVANIA,

*Appellants,*

*v.*

KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND; MINORS, THROUGH THEIR NEXT FRIEND, INDIVIDUALLY AND ON BEHALF OF ALL OTHERS SIMILARLY SITUATED,

*Appellees.*

---

ON APPEAL FROM THE JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA.

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This petition under Rule 58 seeks reconsideration of an order of the Court rejecting the request of the Supreme Court of Pennsylvania for leave to file a brief *amicus curiae* on behalf of the judicial branch of the Pennsylvania government in a case in which a federal three-judge court has imposed duties upon the courts of Pennsylvania even though it recognized that neither federal law nor the United States Constitution requires the state courts to perform these duties.

Because the brief was captioned merely as a brief "for the Supreme Court of Pennsylvania" without reference to the fact that the Supreme Court sought to speak only in its constitutionally mandated position as supervisor and administrator for Pennsylvania's unified judicial system,[1] it is likely that this Court rejected the petition in the belief that the Pennsylvania court spoke on its own behalf and that, if it were permitted to do so, other state trial and appellate courts across the country might assert similar claims to be heard in their own right. But contra the inexplicit caption of the brief amicus curiae, the Supreme Court of Pennsylvania sought to speak in behalf of the unified judicial system of Pennsylvania only, and not on its own behalf. See Alternate Motion for Leave to File Brief on Behalf of Supreme Court of Pennsylvania, *Amicus Curiae*, p. 5.

Furthermore, the brief *amicus curiae* of the Supreme Court of Pennsylvania had the sponsorship of the Attorney General. Therefore, the order of the Court denying leave to file the brief implicitly rejected the filing of the brief despite the sponsorship of the Attorney General of Pennsylvania in accordance with this Court's Rule 42(4) which provides that no consent is required to the filing of an *amicus* brief so sponsored.

1. The pertinent language of Article V, Section 10 of the Pennsylvania Constitution, which imposes these duties and responsibilities upon the Supreme Court of Pennsylvania, is reprinted in Appendix A to this petition.



**PETITION OF THE SUPREME COURT OF PENNSYLVANIA, IN ITS ADMINISTRATIVE ROLE FOR THE UNIFIED PENNSYLVANIA JUDICIAL SYSTEM, AND OF THE ATTORNEY GENERAL OF PENNSYLVANIA, AS SPONSOR, FOR RECONSIDERATION OF DENIAL OF LEAVE TO FILE BRIEF AMICUS CURIAE BY THE SUPREME COURT OF PENNSYLVANIA.**

1. On June 4, 1976, counsel for the Supreme Court of Pennsylvania presented a brief *amicus curiae* on behalf of that court, acting as the judicial arm of the Commonwealth, which brief was supported both by the sponsorship of the Attorney General of Pennsylvania (pp. 3-4) and by an alternate motion for leave to file the brief if the "sponsorship should in any way fail to qualify the Pennsylvania Supreme Court to appear as *amicus curiae* under Rule 42(4)" (pp. 5-7).

2. On June 21, 1976, this Court entered an order that "[t]he motion of the Supreme Court of Pennsylvania for leave to file a brief, as *amicus curiae*, is denied." 44 U. S. L. W. 3737.

3. Although the Supreme Court's brief was merely labeled Brief *Amicus Curiae* for the Supreme Court of Pennsylvania, the brief neither sought to vindicate any decision of the Supreme Court of Pennsylvania nor to protect that court against any increase in litigation before it.[2]

2. Permitting the Supreme Court of Pennsylvania to appear as *amicus curiae* would not set a precedent for the proposition that any court which would face an additional case load as a result of a federal decision has a right to appear in this Court as *amicus*. The order of the court below will not impose on the Supreme Court of Pennsylvania the danger that its own docket will become crowded as a result of the ruling below. Under Article II of the Appellate Court Jurisdiction Act of 1970, 17 Pa. Stat. Ann. §§ 211.201-211.205, the Pennsylvania Supreme Court will face only such appeals in these cases as it chooses to hear as a matter of its discretion under § 204 of the Act, 17 Pa. Stat. Ann. § 211.204.

Rather, that court sought to file the brief on behalf of the judicial branch of the government of the Commonwealth of Pennsylvania.

4. The Supreme Court of Pennsylvania, as the supervisory and administrative head of Pennsylvania's unified judicial system under Article V, Sections 1 and 10 of the Pennsylvania Constitution, is an appropriate body to appear before this Court as *amicus curiae* representing the interests of Pennsylvania's unified judicial system in the face of a holding by a three-judge federal district court imposing duties upon that state's judicial system which it acknowledges are not required by the United States Constitution. In this respect, the Supreme Court of Pennsylvania stands in no different position from the Judicial Councils of various federal circuits which have appeared in this Court as representatives of the interests of the federal judiciary within their respective circuits. See, *e.g.*, **Chandler v. Judicial Council,** 398 U. S. 74 (1970); **Judicial Council v. Nolan,** 406 U. S. 956 (1972); **Judicial Council v. Nolan,** 481 F. 2d 41 (3d Cir.), *cert. denied,* 414 U. S. 880 (1973); see also **Dooling v. Hilbert,** 476 F. 2d 355 (2d Cir.) *cert. denied,* 414 U. S. 878 (1973).

5. It is particularly appropriate that the Pennsylvania Supreme Court be allowed to appear as *amicus* in this case because, in all probability, it would have been permitted to intervene as of right. See **United States v. Terminal Railroad Association,** 236 U. S. 194, 199 (1915); *cf.* **Hunter v. Ohio ex rel. Miller,** 396 U. S. 879 (1969); **United States v. Paramount Pictures, Inc.,** 334 U. S. 131, 176-78 (1948). Should this Court affirm the lower court's holding that hearings are required, the named appellants in this case



would not have a direct interest in whether the precommitment hearings involved are held in the state courts or before some other neutral body.[3] On the other hand, the Pennsylvania Supreme Court, as representative of the state's judicial branch, has a very real interest in asking this Court to hold that a federal district court may not allocate responsibility for these hearings to state courts unless the United States Constitution or a valid federal statute requires that allocation.

6. Moreover, no reason has ever been given to this Court or to the Supreme Court of Pennsylvania why the Pennsylvania Court should not be permitted to file a brief as *amicus curiae*. In refusing his consent to the request of the Pennsylvania Supreme Court's request to file a brief *amicus*—a consent he granted to all others who requested it—counsel for appellees specifically declined to state "at this time" the reason for his action. See the letter of David Ferleger dated May 3, 1976, attached hereto as Appendix B. Thereafter, counsel for appellee did not communicate to the Court either his reason for refusing his consent or, indeed, the fact of his opposition to the motion of the Pennsylvania Supreme Court for leave to file a brief *amicus curiae*.

7. Finally, the sponsorship by the Attorney General comes within the purview of Rule 42(4) of this Court which provides that "[c]onsent to the filing of a brief of an *amicus curiae* need not be had when the brief is presented . . . for a State . . . sponsored by its Attorney General.

3. Nevertheless, the Attorney General of Pennsylvania has raised the issue of the burdens placed upon the Pennsylvania courts, but clearly has not made it his primary concern for the reasons set forth in paragraph 9 below.

. . ." Plainly, the Supreme Court of Pennsylvania, acting on behalf of that state's unified judicial system in its constitutionally imposed administrative role, is as much the state as are the executive or legislative branches of the state government. The fact that the Attorney General, as a member of the executive branch, has chosen to sponsor a brief written by independent counsel for the judiciary is merely a recognition of the doctrine of separation of powers within the Pennsylvania government, and in no way weakens the sponsorship of the brief.

8. Indeed, Rule 42(4) permits the filing of a brief *amicus curiae* without consent when the brief is presented "for a political subdivision of a State . . . sponsored by the authorized law officer thereof." If a township, borough or village has an absolute right to appear before the Court *amicus curiae* through its solicitor, surely the judicial branch of the state government itself has a right to appeal through its counsel, especially when supported by the sponsorship of the state's Attorney General.

9. Relying on the brief of the Supreme Court of Pennsylvania as *amicus curiae* in this case and the fact that the Pennsylvania Court had independent representation pursuant to his policy concerning the separation of powers, the Attorney General of Pennsylvania alluded to but did not elaborate upon the issues analyzed at length in the brief of the Supreme Court of Pennsylvania which he had sponsored. See Brief for Appellants, pp. 62-63.

WHEREFORE, the Supreme Court of Pennsylvania in its supervisory and administrative role under the Pennsylvania Constitution, by its counsel and by the Attorney General of Pennsylvania as sponsor of its brief, requests that this Court reconsider its order of June 21, 1976, and permit the



Supreme Court of Pennsylvania to file the brief as *amicus curiae* lodged with the Court on June 4, 1976.

Respectfully submitted,

ROBERT P. KANE,
*Attorney General of the Commonwealth of Pennsylvania, Sponsor of the Brief of the Supreme Court of Pennsylvania as Amicus Curiae.*

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Dated: July 15, 1976.

## APPENDIX A.

**Pennsylvania Constitution, Article V, Section 10.**
**Judicial Administration.**

(a) The Supreme Court shall exercise general supervisory and administrative authority over all the courts and justices of the peace, including authority to temporarily assign judges and justices of the peace from one court or district to another as it deems appropriate.

(b) The Supreme Court shall appoint a court administrator and may appoint such subordinate administrators and staff as may be necessary and proper for the prompt and proper disposition of the business of all courts and justices of the peace.

(c) The Supreme Court shall have the power to prescribe general rules governing practice, procedure and the conduct of all courts, justices of the peace and all officers serving process or enforcing orders, judgments or decrees of any court or justice of the peace, including the power to provide for assignment and reassignment of classes of actions or classes of appeals among the several courts as the needs of justice shall require, and for admission to the bar and to practice law, and the administration of all courts and supervision of all officers of the judicial branch. . . .



## APPENDIX B.

**[Letterhead of Mental Patient Civil Liberties Project.]**

May 3, 1976

Bernard G. Segal, Esquire
1719 Packard Building
Philadelphia, Pa. 19102

Re: *Kremens v. Bartley*

Dear Mr. Segal,

Some time ago, you orally requested my consent to the filing of an amicus curiae brief in this matter in the United States Supreme Court on behalf of your clients, the Supreme Court and Court Administrator of Pennsylvania. As your request came prior to even the filing of appellant's jurisdictional statement, I declined to agree at that time.

I am now informed by the appellants' counsel that you desire to file a brief "in respect to the limited issue of the impact of the lower court's decision on the Commonwealth judiciary." For various reasons which need not be enumerated at this time, I am unable to consent to the filing of this amicus brief.

I inform you of my decision at this time so that you will have ample opportunity to petition the Court for leave, should you desire to do so.

Sincerely,

David Ferleger
Attorney

cc: N. Watkins
B. Roth

Supreme Court, U. S.
FILED
AUG 3 1976
MICHAEL RODAK, JR., CLERK

IN THE

# Supreme Court of the United States

OCTOBER TERM, 1975

**No. 75-1064**

JACK B. KREMENS, Individually and as Hospital Director of Haverford State Hospital; FRANK S. BEAL, Individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; WILLIAM B. BEACH, JR., Individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,

*Appellants,*

*v.*

KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND; Minors, Through Their Next Friend, Individually and on Behalf of All Others Similarly Situated,

*Appellees.*

**On Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania**

## BRIEF AND APPENDIX OF *AMICUS CURIAE* DEPARTMENT OF THE PUBLIC ADVOCATE, DIVISION OF MENTAL HEALTH ADVOCACY STATE OF NEW JERSEY

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| A. The Division of Mental Health Advocacy is a statutory agency of the State of New Jersey charged with the responsibility to provide legal representation to individuals subject to involuntary civil commitment proceedings | 4 |
| B. Procedural rights for all individuals, including juveniles, facing commitment to a mental institution have been codified in N. J. Ct. R. 4:74-7, effective September 8, 1975 | 8 |
| C. In those juvenile commitment cases in which juveniles were represented by Amicus, Department of the Public Advocate, Division of Mental Health Advocacy, there has been no evidence of exacerbation of familial situations; on the other hand, the dispositions bespeak individualized treatment by counsel and individualized determinations by the Court | 13 |

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## Summary of Argument

The Department of the Public Advocate, Division of Mental Health Advocacy, a statutory agency, has, since September 8, 1975, provided legal representation to individuals facing civil commitment proceedings, including juveniles, pursuant to *New Jersey Court Rule* 4:74-7, under a procedural format similar to the one mandated by the Federal District Court in the instant case (Point I.A, B). *Amicus'* experience in providing such representation effectively rebuts those arguments raised by appellants alleging exacerbation of familial situations and traumatization of the child (Point I.C.).

Similarly, relevant case law, scholarly literature and available empirical evidence further rebut such arguments by appellant. (Point II).

*Amicus* supports the judgment of the court below with respect to its findings of right to counsel, notice, presence at the hearing, and confrontation and cross-examination of witnesses, at such hearings. *Amicus* respectfully takes exception to the District Court's finding with respect to standard of proof (Point III).

IN THE

# Supreme Court of the United States

OCTOBER TERM, 1975

**No. 75-1064**

JACK B. KREMENS, Individually and as Hospital Director of Haverford State Hospital; FRANK S. BEAL, Individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; WILLIAM B. BEACH, JR., Individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,

*Appellants,*

*v.*

KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND; Minors, Through Their Next Friend, Individually and on Behalf of All Others Similarly Situated,

*Appellees.*

**On Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania**

## BRIEF OF *AMICUS CURIAE* DEPARTMENT OF THE PUBLIC ADVOCATE, DIVISION OF MENTAL HEALTH ADVOCACY STATE OF NEW JERSEY

## Interest of *Amicus Curiae*

The instant appeal presents the very important issue of what process is due to juveniles facing civil commitment proceedings. *Amicus curiae,* Department of the Public Advocate, Division of Mental Health Advocacy, is an administrative agency of the State of New Jersey statutorily authorized to represent—both individually and on a class action basis—persons subject to such proceedings, on any issue pertinent to the commitment to, release from, or confinement in mental institutions throughout the State.[1] In such capacity, the Division of Mental Health Advocacy has undertaken to represent both adults and juveniles in commitment matters through procedures very similar to those mandated by the District Court's judgment on review here.

As will be discussed further, *infra* (see Point I.A.) the Division of Mental Health Advocacy has established field offices in two counties to provide representation, on an individualized basis, at commitment proceedings, periodic review hearings, and individual matters concerning conditions of confinement or release.[2] Through this brief, the

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[1] For a discussion of the nature and scope of functions served by the Department of the Public Advocate in general, and the Division of Mental Health Advocacy in particular, see, Note, "The Office of Public Counsel: Institutionalizing Public Representation in State Government", 64 *Georgetown L.J.* 895, 900-902 (1976). See also, Penn, "Advocate From Within", 12 *Trial Magazine* 20, 23 (February 1976).

[2] As noted *infra,* the decision to establish two field offices was primarily a result of the available financial allocations. The entire Division operates on an annual budget of $550,698.00. The two counties

*(Footnote continued on following page)*



Division of Mental Health Advocacy hopes to apprise this Court of its experience in providing legal representation to juveniles subject to the civil commitment process.

The Division of Mental Health Advocacy files this brief as *amicus curiae* with the consent of all parties to this appeal. See, letter from Barry A. Roth, Assistant Attorney General of Pennsylvania, to David Ferleger, Esq., dated May 11, 1976, set forth in the Appendix at 1a.

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*(Footnote continued from preceding page)*

combined accounted for approximately 32.8% of the involuntary commitment proceedings initiated statewide in calendar year 1975 (total number of cases docketed January-December 1975: 3,338; of those, 898 were from Essex County, and 199 were from Mercer County). With respect to persons presently hospitalized (and thereby eligible for Division services) as of the filing of this brief, the total institutionalized population in New Jersey (including state, county, federal, and private facilities) is 5,590; of these, 1,540 are Essex County residents and 273 are Mercer County residents. Thus the two counties combined account for 32.4% of the current patient population.

# ARGUMENT

## I. The New Jersey Department of the Public Advocate, Division of Mental Health Advocacy has, since September 8, 1975 provided juveniles facing civil commitment proceedings representation in a manner similar to the procedural format mandated by the Court below.

### A. The Division of Mental Health Advocacy is a statutory agency of the State of New Jersey charged with the responsibility to provide legal representation to individuals subject to involuntary civil commitment proceedings.

The Division of Mental Health Advocacy, a State agency within the New Jersey Department of the Public Advocate, has express statutory authority to

> provide such legal representation and medical consultation as the director deems appropriate for any indigent mental hospital admittee in any proceeding concerning the admittee's admission to, retention in, or release from confinement in such a hospital, institution or facility. N.J.S.A. 52:27E-24.

Pursuant to this statutory grant, and consonant with the available fiscal appropriations, the Division of Mental Health Advocacy (hereinafter "the Division") has established two field offices to provide legal counsel to individual "indigent mental hospital admittees."[3] These offices

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[3] The Division also maintains a class action office, located in Trenton, with statewide jurisdiction and the statutory authority to

> represent the interests of indigent mental hospital admittees in such disputes and litigation, as will, in the discretion of the Director . . . best advance the interests of indigent mental hospital admittees as a class on an issue of general application to them. . . . N.J.S.A. 52:27E-25.



are located in Newark and Trenton. The former, designated the Essex Regional Office, provides representation at commitment hearings, periodic review hearings,[4] *habeas corpus* hearings, and individual cases involving conditions of treatment or confinement; the population served by this Office is comprised of all Essex County residents who are or may become institutionalized anywhere in the State, as well as the entire patient population at the Essex County Psychiatric Hospital in Cedar Grove. The Trenton office, denominated the Mercer Regional Office, provides the same four types of services to all residents of Mercer County facing institutionalization, including those residing at Trenton Psychiatric Hospital.[5]

The regional offices are staffed by attorneys (three in Trenton, four in Newark) and "field representatives" (three in Trenton, three in Newark). This latter term denotes non-lawyer staff personnel who are, by virtue of background training and prior work experience, mental

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[4] On November 12, 1974, Chief Justice Richard J. Hughes of the New Jersey Supreme Court issued Memorandum #4-74 to all assignment judges, trial court administrators and county clerks, establishing among other procedures, a schedule of periodic reviews of "all persons who are now, or may hereafter become, involuntarily committed" in the State. The memorandum also mandated docketing and scheduling procedures for final commitment hearings which essentially presaged the current N.J. Ct. R. 4:74-7. The full text of the memorandum is set forth in the Appendix at 2a-6a.

[5] The Mercer Regional Office has also assumed responsibility for providing representation to clients residing in Hunterdon County, a smaller, less urban area adjacent to Mercer County. In the past, this office has also provided services to Somerset County residents; since the adoption of N.J. Ct. R. 4:74-7(c)(2), however, responsibility for this representation has been assumed by Somerset County.

health professionals.[6] Although conceived of, by statute, as "law offices", the regional offices operate, in practical effect, as a partnership among all professionals on the staff. The ultimate service provided may be "legal" in nature (*i.e.* serving as counsel or, in the case of a juvenile, as guardian *ad litem* as well, at a legal proceeding such as a commitment hearing or a periodic review) but input into the final result comes from all staff members. The field representative interviews the patient/client initially,[7] and gathers all data pertinent to the type of legal representation called for. In the case of a commitment hearing, the field representative will ascertain (1) the client's current medical/psychological condition as evidenced both by the hospital records and by the field representative's assessment of the client at the time of the interview; (2)

[6] In the Trenton office, the supervising field representative holds a Masters of Divinity degree and had six years of experience in mental health related fields prior to coming to the Division; another field representative holds a Bachelor of Arts degree and had four years prior experience as a social worker; the third field representative holds an Associate of Arts degree and has had two years prior experience in mental health related areas.

Two field representatives in the Newark office hold Masters degrees, one in Psychology, and one in Social Work, and together have more than two years prior experience in mental health related areas. The third holds a Bachelor of Arts degree and had one-and-a-half years prior work experience in related areas.

[7] In the case of a commitment hearing, where the client has been hospitalized under a temporary commitment order, under N.J.S.A. 30:4-37 and 30:4-38, the name is referred to the appropriate regional office by the Office of the County Adjuster in the county of the patient's residence. In the case of periodic reviews (see n.4 *supra* at p. 4), the names of patients whose hearings have been scheduled are referred to the appropriate regional office by the Office of the County Clerk in the county of the patient's residence.



the client's background—both social and medical—and current family situation; (3) the availability of alternative care facilities appropriate to the client's needs; (4) the need for recruiting independent psychiatric testimony to present on behalf of the client at the hearing. For periodic reviews, the field representative will obtain information pertinent to (1) through (4) above, and, in addition, will review the patient's history of hospitalization to evaluate the nature of the care and treatment rendered in an effort to determine if continued hospitalization is appropriate.

The field representative then confers and works closely with the attorney to develop the appropriate legal strategies in light of the individual patient/client's needs and desires. The attorney appears at the hearing as the patient/client's advocate, to advance that individual's desires to the maximum extent feasible. All final legal decisions concerning a given patient are thus bottomed on a joint effort by the two professions represented on the Division's staff.[8]

[8] The Division of Mental Health Advocacy thus provides representation in both individual and class matters in the systemic, organized way contemplated in and urged by the relevant scholarly literature. See, *e.g.*, Andalman and Chambers, "Effective Counsel for Persons Facing Civil Commitment: A Survey, Polemic and a Proposal", 45 *Miss. L.J.* 43, 75-76 (1974); Litwack, "The Role of Counsel in Civil Commitment Proceedings: Emerging Problems", 62 *Calif. L. Rev.* 816, 826, 839 (1974); Note, "The New York Mental Health Information Service: A New Approach to Hospitalization of the Mentally Ill", 67 *Colum. L. Rev.* 672, 689 (1967). For critiques of the role of the occasional or assigned counsel in such matters, see, *e.g.*, Cohen, "The Function of the Attorney and the Commitment of the Mentally Ill", 44 *Tex. L. Rev.* 424, 448, 450, 457-458 (1966); Weihofen, "Mental Health Services for the Poor", 54 *Calif. L. Rev.* 920, 939 (1966); "Developments in the Law—Civil Commitment of the Mentally Ill", 87 *Harv. L. Rev.* 1190, 1288 (1974) (hereinafter "Developments"); Comment, "Liberty and Required Mental Health Treatment", 114 *U. Pa. L. Rev.* 1067, 1068-1070 (1966).

**B. Procedural rights for all individuals, including juveniles, facing commitment to a mental institution have been codified in N.J. Ct. R. 4:74-7, effective September 8, 1975.**

Prior to September 8, 1975, New Jersey civil practice rules provided that a person facing civil commitment receive written notice of the time and place of the final hearing "at least *one day* before the date fixed" N.J. Ct. R. 4:74-7(e) (1969 Rev.) (emphasis added). If the patient was not confined prior to the hearing, service was to be upon him or her personally or upon his or her attorney; if the patient was in an institution prior to the hearings, the county adjuster was required to effect personal service. The prior rules further provided that the "notice shall contain a statement that if the patient desires to oppose the application for a final judgment of commitment, he may appear personally or by attorney at the time and place fixed for the final hearing." *Id.* The decisions whether to hold an actual hearing and whether to have the patient present were completely discretionary with the court. N.J. Ct. R. 4:74-7(f) (1969 Rev.).

Contemporaneously with the institution of litigation challenging the constitutional deficiencies in New Jersey's civil commitment practice under the statutes (N.J.S.A. 30:4-27 *et seq.*) and the rule, the Supreme Court's Civil Practice Rules Committee undertook to revise N.J. Ct. R. 4:74-7. In *In re Geraghty,* 68 N. J. 209, 343 A. 2d 737 (1975), the New Jersey Supreme Court was confronted with the contention that due process requirements, under the Fourteenth Amendment to the United States Constitution and Art. I, Para. 1 of the New Jersey Constitution, mandated affording persons subject to civil commitment proceedings the full panoply of procedural due process guarantees of notice, hearing, right to be present,



confrontation of witnesses, and especially the right to be represented by counsel.

Prior to the Supreme Court's decision in *Geraghty,* the newly revised N.J. Ct. R. 4:74-7 (1975 Rev.) was adopted. The full text of this rule is set forth in the Appendix at 7a-10a. The combined net effect of the current rule and pertinent statutes (N.J.S.A. 30:4-27 *et seq.*) is that civil commitment proceedings in New Jersey now involve, at the least, the following procedural provisions, as a matter of practice:[9]

(1) An order for temporary commitment must be based on an application supported by the typewritten certificates of two physicians licensed in the State of New Jersey, wherein each physician

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[9] Another challenge to the New Jersey civil commitment practice had been lodged in October 1973, in a federal court suit questioning the constitutionality of N.J.S.A. 30:4-37; 4-38; 4-41; and 4-42, as well as N. J. Ct. R. 4:74-7(b),(c), and (e). *Coll* v. *Hyland,* 411 F. Supp. 905 (D. N.J. 1976). The decision of the three-judge court in *Coll* was subsequent to the adoption of the 1975 revision of N. J. Ct. R. 4:74-7 and the decision in *In re Geraghty, supra.* Therefore, the Court weighed Coll's constitutional challenges in light of the new Rule and stated: "[W]e confine our inquiry to the constitutionality of the current rules of court, which are substantially different from those previously in effect." 411 F. Supp. at 907. The Court found the current New Jersey rule to provide constitutionally adequate procedural protections to persons facing involuntary civil commitment. Specifically, the Court rejected Coll's contention that a preliminary hearing was constitutionally required, citing the 20-day limit for final hearings in the New Jersey rule. The *Coll* Court went on to find that the procedures codified by the current New Jersey rule met constitutional muster. "After a thorough review of the New Jersey statutes and procedural rules governing civil commitments, we conclude that constitutional standards have been met. Accordingly, judgment will be entered in favor of the defendants." 411 F. Supp. at 913.

shall state the particular facts relied upon to support commitment;

(2) Such order must provide for a day and place certain on which the final commitment hearing is to be held, which shall be no more than 20 days from either the filing of the application, or the date of the temporary commitment order, or the date of admission of the client to the institution, as the case may be;[10]

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[10] N.J.S.A. 30:4-25 provides:

Classes of commitment

For the purpose of this Title the method of commitment of mentally ill patients shall be divided into 5 classes:

Class A. Where immediate temporary confinement in an institution is not necessary before making final order of commitment.

Class B. Where immediate temporary confinement is necessary, owing to the condition of the patient, and where an order of temporary confinement can be obtained before the patient is taken into such institution.

Class C. Where immediate confinement in an institution before making the temporary order hereinafter referred to is necessary, owing to the condition of the patient, and where an order of temporary commitment cannot be obtained before the patient is taken into such institution.

Class D. Where a person voluntarily applies for admission to an institution for treatment. In all such cases the admission and maintenance shall be governed by the provisions of section 30:4-46 of this Title.

Class E. Where a person in confinement, under care of the chief executive officer of any correctional institution, is to be transferred to an institution for treatment. In all such cases the procedure shall be governed by the provisions of section 30:4-82 of this Title.



(3) Counsel must be appointed, by the temporary commitment order, to unrepresented clients, and juveniles shall be assigned guardians *ad litem* who must be attorneys;

(4) Notice of the final hearing, which must be served *no less than* 10 days prior to such hearing, shall be personally served upon the patient, and shall also be served on the patient's counsel or guardian *ad litem,* the nearest relatives of the patient, the county adjuster and the superintendent of the institution where the patient is confined if such is the case;

(5) The patient, through counsel, has broad discovery rights, *cf. Patients* v. *Kallen,* 123 N. J. Super. 175, 302 A. 2d 142 (App. Div. 1973), as well as the right to the appointment of independent psychiatric experts without charge to the patient, *cf. In re Gannon,* 123 N. J. Super. 104, 301 A. 2d 493 (Somerset Cty. Ct. 1973); *Matter of Alfred,* 137 N. J. Super. 20, 347 A. 2d 539 (App. Div. 1975);

(6) Oral testimony must be taken at the final commitment hearing from a licensed physician who has examined the patient since the date of the temporary order;

(7) The patient must be present at the hearing unless good cause is shown for excluding him or her;

(8) A final order of commitment shall provide a schedule of periodic reviews to be conducted in the manner required for final commitment hearings;

(9) If an order is entered, at the final commitment hearing discharging a temporarily confined patient, such order may establish conditions for discharge such as attendance at a mental health care facility on an out-patient basis, *cf. State* v. *Carter,* 64 N. J. 382, 316 A. 2d 449 (1974).

Minors are afforded the same procedural protections as adults in civil commitment proceedings irrespective of who makes the original application for the minor's commitment. Specifically with respect to juveniles, N. J. Ct. R. 4:74-7(j) provides:

> Commitments of Minors. No minor shall be committed except temporarily to a mental institution for treatment and care of an alleged mental condition on the application of his parent or parents or other person in loco parentis except on court order after hearing pursuant to paragraph (e) hereof. A guardian ad litem who shall be a person other than the applicant for the commitment, shall be appointed by the court to represent the interests of the minor at such hearing.

The comment to this section of the rule indicates that it is "intended to prevent a so-called voluntary commitment of a minor by his parent or other person in loco parentis".[11] Pressler, *Current N. J. Court Rules,* Comment

[11] N.J.S.A. 30:4-46, entitled "Voluntary application for admission for treatment", provides, in pertinent part:

> [A] minor under the age of [18] in whose behalf an application for voluntary admission has been made by a parent or guardian or by a grandparent or adult brother or sister, may be admitted to any public or private mental hospital by filing, or having filed in his behalf, with the chief executive officer, at the time of his admission, an application in writing to be approved and furnished by the board of managers or the board of chosen freeholders or the private mental hospital, as the case may be. . . .



R. 4:74-7, at 803. N. J. Ct. R. 4:74-7(c)(2) provides: "If the patient is a minor, a guardian ad litem shall be appointed who shall be an attorney." When read together, the two sections clearly indicate that the role of the attorney envisioned by the Rule with respect to juveniles is that of attorney *and* guardian *ad litem.* This flexible posture enables the attorney to employ all available resources—legal, medical and social, institutional and non-institutional—to achieve a judicial result appropriate to the particular needs and wishes of the individual juvenile.[12]

**C. In those juvenile commitment cases in which juveniles were represented by *Amicus,* Department of the Public Advocate, Division of Mental Health Advocacy, there has been no evidence of exacerbation of familial situations; on the other hand, the dispositions bespeak individualized treatment by counsel and individualized determinations by the Court.**

The revision of N. J. Ct. R. 4:74-7, effective September 8, 1975, guaranteed that thenceforth civil commitment proceedings of juveniles would be considered adversarial in nature to the extent that all procedural protections afforded to adults in such matters are to be extended to juveniles.

Since the promulgation of the revised rule, Division field offices have undertaken to provide—in Mercer and Essex counties—attorney and guardian *ad litem* services as required by N. J. Ct. R. 4:74-7(c)(2) and (j). This has involved the delivery of the four types of services discussed *supra* at p. 5, but on a somewhat broader level

[12] See further discussion on the role of counsel generally at Points I.C and II, infra.

than for adult clients. As will be discussed further below, the assignment of a guardian *ad litem* role to Division attorneys has placed these attorneys in a unique position *vis-à-vis* the court and the applicant for commitment. The role of counsel in juvenile commitment proceedings, as effectuated by Division attorneys, has taken on new dimensions of responsibility and authority.

As of mid-July, 1976, the two field offices combined have represented approximately 77[13] juveniles since September 8, 1975. The vast majority of these clients have been between the ages of fourteen and seventeen, although the Division has represented children as young as seven years of age.[14]

In the 71 juvenile cases closed by the Mercer and Essex County field offices of *amicus* Department of the Public Advocate, Division of Mental Health Advocacy, since the

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[13] This number indicates those juveniles represented, by Division staff, both at civil commitment proceedings and at periodic review hearings. It should be noted that the class of juveniles served by the Division is distinguishable from the plaintiff class in *Bartley* insofar as the latter class includes juveniles subject to placement in facilities for the mentally retarded, while the former is limited to juveniles currently residing in, or facing commitment to, a "mental institution for treatment and care of an alleged mental condition" [N. J. Ct. R. 4:74-7(j)]—*i.e.* a *psychiatric* facility. At present in New Jersey, procedures for admission to any of the State services for the mentally retarded (State schools, residential services, day care training services) are either essentially administrative in nature or are integrated into otherwise pending juvenile court proceedings, and therefore are not subject to the provision of N. J. Ct. R. 4:74-7. See N.J.S.A. 30:4-25.1, 4-25.6.

[14] As of July 16, 1976, the precise break-down in terms of age levels was as follows: age 7-1; age 8-1; age 9-1, age 11-1; age 12-2; age 13-3; age 14-6; age 15-15; age 16-19; age 17-24.



September 1975 revision to N. J. Ct. R. 4:74-7(j),[15] the dispositions reveal a pattern of individualized court determinations.[16] In addition, the dispositions of the cases reveal that counsel—in New Jersey—fulfills those multiple functions urged by respected commentators. See, *e.g.*, Ellis, "Volunteering Children: Parental Commitment of Minors to Mental Institutions", 62 *Calif. L. Rev.* 840, 888-890 (1974) [hereinafter "Volunteering Children"] (discussed specifically at Point II, p. 31, *infra*); see also Stone, *Mental Health and Law: A System in Transition* 59, 233-237 (1975).

Thus, of the 71 closed files, 19 of the juveniles were discharged following the involvement of *amicus* as counsel but prior to a formal hearing, six were released at such a hearing (in virtually all cases to their parents' or guardian's custody), eight were "discharged pending placement,"[17] four were "discharged pending placement" to a facility administered by New Jersey's Division of Mental Retardation,[18] two were "discharged pending place-

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[15] As of the preparation of this brief, six cases remain open.

[16] All statistics are on file with *amicus* Department of the Public Advocate, Division of Mental Health Advocacy.

[17] The phrase "discharge pending placement"—apparently unique to New Jersey practice—covers those cases in which orders are entered discharging patients subject to the availability of a suitable alternative care or aftercare facility. These orders are usually accompanied by retention of jurisdiction by the Court to insure that the placements are, indeed, made within the specific time limits contained in the order. *Cf. Dixon* v. *Weinberger*, 405 F. Supp. 974 (D.D.C. 1975).

[18] See generally, N.J.S.A. 30:4-165.1 *et seq.*

ment" to a residential school,[19] one was discharged to the custody of Division of Mental Retardation officials, three were discharged subject to certain conditions,[20] one was transferred to an out-of-state hospital,[21] one was ordered admitted to a special education program while institutionalized,[22] and three were remanded to local jails or youth detention facilities to await trial on criminal offenses or hearings on juvenile deliquency petitions. In addition, in two cases, adjournments were entered (so as to facilitate residential school placement and to avert the potentially stigmatic effect of a commitment label),[23] and in ten cases, voluntary applications were accepted.[24] Finally, in 11 cases, commitment was ordered.[25]

These statistics reflect, then, individual determinations on individual bases. Dispositions are not limited to a finite commit/release paradigm (a fear often articulated by those who see the involuntary civil commitment pro-

[19] See generally, N.J.S.A. 18A:46-9, 13, 14, 15 (amended July 1, 1976).

[20] *E.g.*, that the juvenile participate in a specific aftercare program.

[21] See generally, N.J.S.A. 30:7B-1 *et seq.*

[22] This, *e.g.*, required the release of certain funds by the board of education in the municipality in which the juvenile resided. See generally, N.J.S.A. 18A:46-13, 14 (amended July 1, 1976).

[23] See generally, "Volunteering Children", *supra*, at 845-848.

[24] See *In re Williams*, 140 N. J. Super. 495, —— A. 2d —— (Essex Cty. J.D.R. Ct. 1976).

[25] Of these eleven cases, five juveniles have subsequently been discharged and one other has been "discharged pending placement."



cess as taking on all of the trappings of the criminal trial);[26] on the other hand, they are specifically structured so that an individualized determination can be made, following the full participation of counsel at all relevant stages of the proceedings,[27] in the manner contemplated by, *inter alia*, Ellis, Stone and Cohen, all *supra*.

Indeed, the roles played by *amicus* in the cases in question have gone far beyond simple trial representation: in many of those cases in which *amicus* was appointed guardian *ad litem* as well as counsel,[28] orders were entered continuing the Division as guardian *ad litem* beyond the actual formal commitment (or acceptance of the voluntary application) so as to facilitate and insure the implementation of an aftercare plan. In other cases, *amicus* has played an active role in such areas as facilitation of school placement,[29] assisting the family in obtaining an appropriate community education program for the juvenile,[30] representing juveniles on individualized right to treatment,[31] or right to obtain Medicaid funds,[32] facilita-

[26] See, for such a view, Peszke, *Involuntary Treatment of the Mentally Ill* (1975).

[27] The periodic review process is, of course, available to juveniles in New Jersey in the same manner as it is to adults. See N. J. Ct. R. 4:74-7(f), (j).

[28] See N. J. Ct. R. 4:74-7(j).

[29] A corollary of such a role is, of course, its inverse: *amicus* also has acted to deter inappropriate placements.

[30] See generally, N.J.S.A. 18A:46-14 (amended July 1, 1976).

[31] See, *e.g.*, N.J.S.A. 30:4-24.1 (amended May, 1975); *In re D.D.*, 118 N. J. Super. 1, 285 A. 2d 283 (App. Div. 1971).

[32] See generally, 42 U.S.C.A. § 1395 *et seq.*

tion of an available family therapy program, provision of independent psychiatric expertise to the family so that the juvenile could readjust to his home setting after commitment,[33] resolution of conflicts between social service agencies (*e.g.,* Division of Youth and Family Services) and the juvenile's family, and finding suitable aftercare or alternative care placements. These various functions, again, reflect a "counseling attitude" that far transcends the narrow range of choices often feared as a necessary concomitant to the presence of adversarial counsel.

In addition, it appears that—in most cases—parents were affirmatively pleased with the involvement of *amicus.* Although parents were hostile to the role of adversary counsel in a handful of cases, in the vast majority, parents were described by *amicus* counsel as "enthusiastic about our involvement," "thankful for involvement," "receptive," "cooperative," "positive," "helpful," and "interested and informative." Interestingly, in at lease four cases, parents who began with "negative" feelings or who were "uncooperative" with counsel, radically changed their attitudes during the course of representation and became "positive" or "cooperative" by the time of the final hearing.[34] In these cases, it would appear that counsel had the precise opposite effect of that feared by appellants: rather than

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[33] In this case, following acceptance of the juvenile's own voluntary application, he was subsequently discharged and is now receiving out-patient treatment at home.

[34] As part of the preparation of this brief, the Mercer and Essex Regional Offices of the Division of Mental Health Advocacy were asked for statistical read-outs on their respective juvenile cases. One statistical category asked for "response of family" (to legal representation of the juvenile by Division attorneys), in response to which subjective answers such as those appearing in the text were received.



exacerbating tensions, the presence of counsel actually served to alleviate such feelings and strengthen interfamilial bonds.[35]

Finally, the presence of counsel has led to exceptional judicial creativity in an area in which, most likely, such creativity would be conspicuously absent but for the presence of an adversarial role. In *In re Pamela T.,* Docket No. ESCC 16-68 (Essex Cty. J.D.R. Ct. 1975), a "treatment program" mainly consisting of over 200 electroshock applications and 23 hours a day in seclusion—structured in response to the "behavior problems" of a young girl with an organic brain condition—was struck down as violative of the Eighth Amendment's ban on cruel and unusual punishment;[36] in *In re Williams,* 140 N. J. Super. 495, 499, —— A. 2d —— (Essex Cty. J.D.R. Ct. 1976), the court held that a juvenile—on his own—could voluntarily admit himself to an institution (thus avoiding the stigma inherent in an involuntary commitment) if he "understood the nature of a voluntary commitment and grasped the significance of the . . . proceedings"; in *In re D.G.,* Docket No. HNCC 1-76 (Hunterdon Cty. Ct. 1976), the court held that all documents and records pertaining to the involuntary commitment proceeding be impounded

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[35] Another phenomenon worth noting is that, in those cases in which counsel either represented the juvenile on treatment questions or actively sought an after-care or out-patient program, in virtually all instances, parents were especially positive about Division of Mental Health Advocacy involvement.

[36] *Cf. Rozecki* v. *Gaughan,* 459 F.2d 6, 7 (1 Cir. 1972). The *Pamela T.* case received widespread press attention following entry of the court order. See, *e.g.,* Jaffe, "'Horror Story' at Greystone Ends for Girl", *Newark Star-Ledger,* Vol. 62, No. 79, p. 1, col. 7 (May 12, 1975). All orders in juvenile commitment cases are on file with the Division of Mental Health Advocacy.

"to protect the interests of the juvenile." Finally, in *In re G.G.*, Docket No. MECC 164-75 (Mercer Cty. Ct. 1975), in which *amicus* represented a juvenile whose condition had been gravely deteriorating on whom psychotropic medication was having no positive effect, and where both the juvenile's independent psychiatric expert witness and the hospital physician advocated the use of electroshock, *amicus* petitioned the court to determine the need for such treatment.[37] Following the hearing, the treatment was ordered and administered, and the juvenile has been subsequently discharged.[38]

Cases such as these reflect the end results of the presence of counsel: the presentation to the courts of individual cases in a manner susceptible to individualized, creative determinations. Clearly, fears such as those expressed by appellants as to the involvement of counsel

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[37] In a letter to the Court, the attorney arguing the case stated:

> In the case at hand, I believe it should be the role of counsel, not to blindly resist treatment, but to assist the court in monitoring the decision process of the medical professionals. . . . To this end, I intend to elicit testimony at the forthcoming hearing regarding the availability of alternatives to electroshock therapy, the risks associated with its use, and the chances for negative results in addition to testimony supporting the use, so that a detailed background will exist upon which the Court may render its decision.

Letter from Herbert D. Hinkle, Esq., counsel for juvenile, to Honorable George Y. Schoch, Assignment Judge, Superior Court, Law Division, Mercer County, N.J., November 26, 1975, in *In re G.G.* *supra*.

[38] This case is described in greater detail in Perlin, "The Right to Refuse Treatment in New Jersey", 6 *Psychiatric Annals* 300, 304 (1976).



appear groundless. A system which affords counsel and other procedural protections to juveniles facing commitment is eminently workable.

## II. There is no empirical evidence that appointment of independent counsel to represent juveniles facing commitment either "traumatizes" the child or "heightens intrafamilial hostilities".

In suggesting that the District Court's decision will lead to an "exacerbat[ion]" of problems, and a heightening of "intrafamilial hostilities", Ab at 45, through an experience "traumatizing for the child and for the family," Ab at 36, fn. 28, appellants cite no empirical evidence, save one unpaginated allusion to—apparently—the transcript below, *id.*, and the reference to one family law journal article, *id.* It is submitted that their bald assertions are groundless, and that, on the other hand, those statistical surveys which *have* been done in analogous fields, paint a picture diametrically opposed to that suggested by appellants.[39]

It is clear that counsel plays a critical, and in some cases, nearly dispositive role in involuntary commitment

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[39] Indeed, the article so cited by appellants—Duncan, "Recognition and Protection of the Family's Interests in Child Abuse Proceedings," 13 *J. Family L.* 803 (1973)—notes that, when the rights of parents and child "come into conflict . . . it is the duty of the state to resolve the conflict, and at the same time make every effort to protect the rights of all the parties involved," *id.* at 806, that this conflict "can only be resolved by a judicial proceeding", *id.*, and that, "where the state can not adequately represent all the interests of the child, *due process may require separate counsel for the child*," *id.*, at 812 (emphasis added). These arguments clearly do not buttress appellants' approach.

proceedings—where active attorneys are employed, fewer persons are committed, "Developments," 87 *Harv. L. Rev., supra,* at 1285; Wenger and Fletcher, "The Effect of Legal Counsel on Admissions to a State Mental Hospital: A Confrontation of Professions," 10 *J. Health and Soc. Behavior* 66, 69 (1969) (74% of represented persons studied were released; only 9% of those not represented discharged); Kumasaka and Stokes, "Involuntary Hospitalization: Opinions and Attitudes of Psychiatrists and Lawyers," 13 *Comprehensive Psych.* 201 (1972); Kramer, "Protective Legal Services for the Mentally Ill," 23 *Hosp. and Commun. Psych.* 41, 42 (1972) (study of Mental Health Information Service in New York revealed 40.4% of all patients requesting hearings through counsel released by hospital psychiatrists prior to hearing), and that "intervention by counsel acting as patient's attorney tremendously increases chances of discharge, not to mention the other alternatives to hospitalization that may also be worked out to the patient's satisfaction," Gupta, "New York's Mental Health Information Service: An Experiment in Due Process," 25 *Rutgers L. Rev.* 405, 438 (1971). See also, Silverberg, "The Civil Commitment Process: Basic Considerations", 1 *Legal Rights of the Mentally Handicapped,* 103, 109 (Ennis and Friedman eds. 1973).[40]

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[40] Significantly, this conclusion was adopted in *Lessard* v. *Schmidt,* 349 F. Supp. 1078, 1099 (E.D. Wis. 1972), vacated on other procedural grounds, 414 U.S. 473 (1974), on remand 379 F. Supp. 1376 (E.D. Wis. 1974), vacated and remanded on other grounds 421 U.S. 957 (1975), as evidence that the traditional guardianship appointment does not satisfy constitutional requirements for counsel as it is not sufficiently an advocacy role. See also, Dix, "Hospitalization of the Mentally Ill in Wisconsin: A Need for Reexamination," 51 *Marq. L. Rev.* 1, 33 (1967); *Quesnell* v. *State,* 83 Wash. 2d 224, 517 P. 2d 568, 576 (Sup. Ct. 1974) (citing *Lessard* with approval).

*(Footnote continued on following page)*



Appellants' other attempts to inject "empirical" data, simply fall wide of the mark. They suggest that "the relative uncertainty of diagnosis in the area is often exaggerated and sensationalized," Ab at 42, citing only to an as-yet-unpublished critique[41] of the Rosenhahn study,[42] and Chief Justice Burger's concurring opinion

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*(Footnote continued from preceding page)*

See Epstein and Lowinger, "Do Mental Patients Want Legal Counsel? A Survey," 45 *Am. J. Orthopsychiat.* 88, 91-92 (1975) (majority of patients studied indicated need for legal aid in both court-related hospitalization proceedings as well as in non-hospital-related matters). The authors note that the effects of legal aid would include a diminution of the numbers of persons involuntarily committed, heightened efficiency of hospital operations (counsel serving as an effective check to insure the presence of therapy), and a change in the image of the hospital as a "total institution." Significantly, the authors point out that the process of conducting the survey was "not traumatic to either the patient or the institution."

[41] Roth, "Some Comments on Labeling,"—*Bull. Am. Acad. Psych. & L.*—(1976).

[42] Rosenhahn, "On Being Sane in Insane Places," 179 *Science* 250 (1973). The Rosenhahn methodology has been the subject of extensive debate and cross-debate in the scientific community. See, *e.g.,* Fleischman, "Letters," 180 *Science* 356 (1973); Israel, *id.* at 358; Burr, *id.;* Hoaken, *id.;* Thaler, *id.;* Zucker, *id.* at 360, Hanley, *id.;* Ostow, *id.* at 361; Lieberman, *id.;* Hunter, *id.;* Pinsker, *id.* at 362; Blair, *id.* at 363; Reich, *id.;* Wiedeman, *id.* at 364; Pattison, *id.* at 365; Rosenhahn, *id.* at 366; Weiner, "'On Being Sane in Insane Places': A Process (Attributional) Analysis and Critique," 84 *J. Abnormal Psychol.* 433 (1975); Spitzer, "On Pseudoscience in Science, Logic in Remission, and Psychiatric Diagnosis: A Critique of Rosenhahn's 'On Being Sane in Insane Places,'" 84 *J. Abnormal Psychol.* 442 (1975); Crown, "'On Being Sane in Insane Places': A Comment from England," 84 *J. Abnormal Psychol.* 453 (1975); Millon, "Reflections on Rosenhahn's 'On Being Sane in Insane Places,'" 84 *J. Abnormal Psychol.* 456 (1975); Rosenhahn, "The Contextual Nature of Psychiatric Diagnosis," 84 *J. Abnormal Psychol.* 462 (1975).

in *O'Connor* v. *Donaldson*, 422 U. S. 563, 584 (1975). They argue further that, if indeed there is uncertainty, that uncertainty "only serves to emphasize the questionable worth of having judges, completely untrained in the field of psychiatry, issuing diagnoses, prescribing treatment, or even choosing between two conflicting diagnoses." Ab at 43. This approach, unfortunately, misreads both existing case law and virtually all empirical, legal, and behavioral studies done in this area.[43]

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[43] The evidence demonstrates that psychiatrists are no more significantly predictively accurate than non-psychiatrists (*e.g.*, lawyers). See Rappeport, Lassen, and Gruenwald, "Evaluation and Follow-up of Hospital Patients who had Sanity Hearings," in Rappeport ed., *Clinical Evaluation of the Dangerousness of the Mentally Ill* 89 (1969) ("The comparison between court released and hospital released adjustment rates shows no significant difference in the predictive accuracy of either institution"), and Ennis and Litwack, "Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom," 62 *Calif. L. Rev.* 693, 749 (1974) (no evidence found that a psychiatrist can predict dangerousness more accurately than a lawyer). In fact, a recent report prepared by the American Psychiatric Association concludes that "neither psychiatrists not anyone else have reliably demonstrated an ability to predict future violence or 'dangerousness.'" American Psychiatric Association, *Clinical Aspects of the Violent Individual* 28 (1975).

Of course, in the famous study of the so-called "Baxstrom patients" (those persons ordered released from New York's maximum security facilities for "insane criminals" following this Court's decision in *Baxstrom* v. *Herold*, 383 U.S. 107 (1966)), it was found that, of the 969 *Baxstrom* patients who had previously been statutorily incarcerated in maximum security facilities, within one year, only *seven* were recommitted to such a facility on a finding of dangerousness (although it had been predicted by hospital officials that nearly 250 would need that type security), and, of the 147 patients released to the community, only *one* had been arrested within that time period (for petty larceny). Hunt and Wiley, "Operation Baxstrom After

*(Footnote continued on following page)*



First, in its decision last year in *O'Connor*, this Court characterized a similar argument as "unpersuasive", adding:

> Where "treatment" is the sole asserted ground for depriving a person of liberty, it is plainly unacceptable to suggest that the courts are powerless to determine whether the asserted ground is present. 422 U. S. at 574, n. 10.

Indeed, as Federal Judge David Bazelon has pointed out:

> When the limited function of a judge in reviewing administrative determinations is borne in mind, there seems little to distinguish psychiatry from, say, radio broadcasting. No judge would claim the ability to provide a particular therapy for a

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*(Footnote continued from preceding page)*

One Year," 124 *Am. J. Psychiat.* 124 (1968), reprinted in Association of the Bar of the City of New York, *Mental Illness, Due Process and the Criminal Defendant* 224 (1968). The *Baxstrom* patients have received special behavioral scrutiny. See, *e.g.*, Steadman, "Follow-up on Baxstrom Patients Returned to Hospitals for the Criminally Insane," 130 *Am. J. Psychiat.* 317 (1973); Steadman and Cocozza, *Careers of the Criminally Insane* (1974). For a more recent evaluation and survey of the relevant literature, see Steadman and Cocozza, "We Can't Predict Who Is Dangerous," *Psychology Today* 32 (January 1975). See also, *e.g.*, Dershowitz, "The Law of Dangerousness: Some Fictions About Predictions," 23 *J. Legal Ed.* 24 (1971); Steadman, "Some Evidence on the Inadequacy of the Concept and Determination of Dangerousness in Law and Psychiatry," 1 *J. Psych. & L.* 409 (1973); Wenk, Robison and Smith, "Can Violence Be Predicted?" 18 *Crime & Delinq.* 393 (1972); Kozol, Boucher, and Garofola, "The Diagnosis and Treatment of Dangerousness," 18 *Crime & Delinq.* 371 (1972); Dershowitz, "Dangerousness as a Criterion for Confinement," 2 *Bull. Am. Acad. Psych. & L.* 172 (1974).

> "chronic undifferentiated schizophrenic." But neither would any judge allocate frequencies to avoid interference. That is not his task in any case; his role rather is to determine whether a capable expert has studied the problem fully and reached a defensible result.

Bazelon, "Implementing the Right to Treatment," 36 *U. Chi. L. Rev.* 742, 745 (1969); see also, Bazelon, "Psychiatrists and the Adversary Process," *Scientific Am.*, Vol. 230, No. 6 (June 1974), at 18, 23.[44]

Similarly, whereas it has been suggested that the presence of counsel at an involuntary civil commitment proceeding for adults "wholly abdicates medical considerations in favor of a monolithic dedication to legalisms," Stone, *supra* at 58 (quoting other doctors) or that it might prove detrimental to the patient's medical interests, Kadish, "A Case Study in the Signification of Procedural Due Process—Institutionalizing the Mentally Ill," 9 *W. Pol. Q.* 93, 96 (1956), and that—often—counsel itself provides "little more than *pro forma* representation [to]

[44] Appellants' arguments closely mirror those made by Judge Paul Alexander of Ohio: that, in extending the panoply of procedural due process rights to juveniles, "we open the door to a number of undesirable and potentially dangerous factors; so that . . . we may be doing him a disservice, and injustice," Alexander, "Constitutional Rights in Juvenile Court," 46 *A.B.A.J.* 1206, 1210 (1960), as quoted in Kittrie, *The Right to be Different* 140 (Pelican ed. 1973). It is suggested that this "fear of undue process," noted by Kittrie, *id.* at 156, is similarly inapplicable to the instant matter. Just as this Court's "vigorous exten[sion]" of procedural due process to children, "Volunteering Children," *supra*, at 876, has been neither a "disservice" nor an "injustice" to them, its logical continuation to the civil commitment process could take place without the feared exacerbation of familial relationships.



the allegedly mentally ill," Litwack, 62 *Calif. L. Rev., supra,* at 818, courts have consistently held that the right to counsel does apply to such proceedings "in which the liberty of an individual is at stake . . . whether [or not] the proceedings be labeled 'civil' or 'criminal' or whether the subject matter be mental instability or juvenile delinquency," *Heryford* v. *Parker,* 396 F. 2d 393, 396 (10 Cir. 1968); see also cases cited at Point III, pp. 36-37, *infra.*[45]

In cases involving the right of a mentally handicapped child to a free public education, see, *e.g., Pennsylvania Association for Retarded Children* v. *Pennsylvania,* 343 F. Supp. 279, 303-306 (E.D. Pa. 1972), [hereinafter *P.A. R.C.*] wherein each child is entitled to a due process hearing as to his placement and/or special class assignment, such judicial intervention had been seen by some as "a substantial threat to the stability of the education system," Weintraub and Abeson, "Appropriate Education for all Handicapped Children: A Growing Issue," 23 *Syr. L. Rev.* 1037, 1057 (1972), as an infringement upon the "exclusive province of the schools," Kirp and Kirp, "The Legalization of the School Psychologists' World," 14 *J.*

[45] Of course, in other areas of substantive law involving the rights of those institutionalized in psychiatric facilities, Federal courts have willingly applied to juvenile cases the reasoning of decisions originally rendered in matters involving adults. See, *e.g., Morales* v. *Turman,* 364 F. Supp. 166, 175 (E.D. Tex. 1973) supplemented 383 F. Supp. 53 (E.D. Tex. 1974), applying the law of *Wyatt* v. *Stickney,* 325 F. Supp. 781 (M.D. Ala. 1971), 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373 (M.D. Ala. 1972), 344 F. Supp. 387 (M.D. Ala. 1972), aff'd *sub. nom. Wyatt* v. *Aderholt,* 503 F. 2d 1305 (5 Cir. 1974) (right to treatment); *King* v. *Carey,* 405 F. Supp. 41 (W.D.N.Y. 1975), applying the law of *Wyatt, supra* (appliciability of Thirteenth Amendment), and *Souder* v. *Brennan,* 367 F. Supp. 808 (D.D.C. 1973) (right to compensation for labor providing consequential economic benefits to institution).

*School Psychol.* 83, 87 (1976),[46] and had been greeted, in some quarters, by "willful noncompliance" on the part of school districts, "Legal Reform," *supra,* at 52, quoting First and Interim Report of the Masters at 69 (filed Aug. 2, 1973), in *P.A.R.C., supra,* and by "resistance" on the part of many vocational educators, "Legal Reform," *supra* at 71-72. See generally, Herr, "Retarded Children and the Law: Enforcing the Constitutional Rights of the Mentally Retarded," 23 *Syr. L. Rev.* 995 (1972).

Interestingly, although counsel at due process hearings was not made mandatory,[47] parents represented by counsel were "significantly more likely to win a favorable ruling" than those not so represented, "Legal Reform," *supra* at 79, results which closely parallel findings of similar surveys involving involuntary civil commitment hearings, see, *e.g.,* articles cited at point II, p. 22, *supra.* Significantly, in discussing the scope of the due process hearing, Kirp, Buss and Kuriloff point out:

[46] Similarly, following the decision of the District Court in *Mills* v. *Board of Education,* 348 F. Supp. 866, 875 (D.D.C. 1972) (due process requires a hearing prior to "exclusion, termination or classification into a special program"), a teachers' union leader direly warned that his group could not be "held responsible for the education of any child in the district while forced [by *Mills*] to keep unruly children in school." Kirp, Buss and Kuriloff, "Legal Reform of Special Education: Empirical Studies and Procedural Proposals," 62 *Calif. L. Rev.* 40, 89 (1974) [hereinafter "Legal Reform"], quoting *Washington Post,* May 2, 1973, at C-1, Col. 7. *Cf. Goss* v. *Lopez,* 419 U.S. 565 (1975).

[47] Under the *P.A.R.C.* decree, a parent is notified he has the "right to be represented at the [due process] hearing by any person of his choice, including legal counsel," 343 F. Supp. at 304, but no explicit provision is made for appointment of counsel to the indigent.



> It is wrong, of course, to assume that the parents' and the child's interests will never vary. Sometimes they will clearly conflict. For example, a parent may want to "get rid of" a child he considers a nuisance or a burden, or might resist appropriate and beneficial placement in a particular special education program because he fears some resulting stigma. Often such conflicts cannot be detected, and, to some extent, parent-child conflicts must simply be tolerated. Nevertheless, the governing procedures should include a provision for appointment of a guardian *ad litem* to represent the child's separate interests when there is evidence of a significant conflict of interest.

"Legal Reform," *supra,* at 125-126.

On the other hand, arguments similar to those made by appellees have been specifically echoed in scholarly and professional literature concerned with due process and the placement of juveniles. Speaking of custody and divorce proceedings, Anna Freud, Joseph Goldstein and Joseph Solnit argue forcefully that the presumption that a child's parents are "generally best suited to represent and safeguard his interests . . . shoud not prevail [where neither parents nor the State] . . . have a conflict-free interest in representing the child." Goldstein, Freud and Solnit, *Beyond the Best Interests of the Child* 65-66 (1973). In such cases it is "crucial [to make] . . . adequate provision for [the child's] . . . personal representation by counsel who has no other goal than to determine what is the least detrimental alternative for his client." *Id.* at 66. See also, Kleinfield, "The Balance of Power Among Infants, Their Parents, and the State," Part I, 4 *Fam. L.Q.* 320, 323, 324 (1970) ("[W]ithout counsel, rights [of children] not only fail to be vindicated; they

fail also to be created"); Note, "On the Voluntary Admission of Minors," 8 *Mich. J. Law Reform* 189, 213-214 (1974) ("In almost any context in which the status, position, or future placement of a minor is involved, the minor should be provided with counsel. It is simply unrealistic for another party to an action, who had his own interests with which to be concerned, to be expected to adequately safeguard those of a minor involved in the matter)."[48]

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[48] Accord, Kleinfield, 4 *Fam.L.Q., supra,* at 347; Katz, "Children, Privacy and Nontherapeutic Experimentation," 45 *Am. J. Orthopsychiat.* 802, 807 (1975); Knitzer, "Child Advocacy: A Perspective," 46 *Am. J. Orthopsychiat.* 200 (1976).

This Court has articulated this argument in a similar context just last month in *Planned Parenthood of Central Missouri* v. *Danforth,* 44 U.S.L.W. 5197, 5203-5204 (July 1, 1976), in striking down a Missouri statute which had required parental or other guardian consent to most first trimester abortions if the woman involved was under 18 and unmarried. Although the Court noted that the Federal District Court had suggested there was a significant state interest in the safeguarding of the family unit and of parental authority, 392 F. Supp. 1362, 1370 (E.D. Mo. 1975), it rejected this as an across-the-board rule:

> It is difficult, however, to conclude that providing a parent with absolute power to overrule a determination, made by the physician and his minor patient, to terminate the patient's pregnancy will serve to strengthen the family unit. Neither is it likely that such veto power will enhance parental authority or control where the minor and the nonconsenting parent are so fundamentally in conflict and the very existence of the pregnancy already has fractured the family structure. Any independent interest the parent may have in the termination of the minor daughter's pregnancy is no more weighty than the right of privacy of the competent minor mature enough to have become pregnant.

*Id.* at 5204. *Cf. In re Smith,* 16 Md. App. 209, 295 A. 2d 283 (Ct. Spec. App. 1972) (mother could not force teenage daughter to have an abortion under applicable state law).



Thus, in his seminal article on the right of children to independent counsel prior to "voluntary" civil commitment, Mental Health Law Project staff attorney James Ellis reviews the development of due process safeguards at juvenile delinquency proceedings and at involuntary civil commitment matters, notes the "negligible role" currently played by counsel in the juvenile commitment process, "Volunteering Children," *supra,* at 881, and sketches the multiple roles that independent counsel should have at such a hearing, including *inter alia,* ascertaining the juvenile's true wishes, explaining possible outcomes to the client (including specifically, potential restrictivity of setting, alternative treatment modalities, facility regulations, etc.), counseling the client on consequences of hospitalization, and "present[ing] . . . [the client's] wishes in as effective a manner as possible." *Id.* at 888-889. He adds further, in an effective partial response to appellants' arguments here:

> Finally, while the lawyer should try to avoid becoming a middle person in future power struggles between the client and the hospital (or parents) because of the detrimental impact that might have on the client's acceptance of ordered treatment, it is appropriate for the attorney to reassure the client that counsel will again be available at the time of the periodic review of commitment, and may also be available if problems arise concerning in-hospital civil liberties. The knowledge that there is someone on the "outside" who is concerned about his or her fate after hospitalization may be one of the most valuable things a lawyer can give to a child-client.

*Id.* at 890 (footnote omitted).[49]

It is suggested that the District Court decision in this matter correctly perceived the importance of the need for "someone on the 'outside'," *id.*, in the same manner as this Court has found such a need to exist in the parallel area of juvenile delinquency proceedings, and as other courts have found in matters involving both involuntary hospitalization and educational placements of the non-institutionalized.

## III. The District Court was correct in holding that the guarantees required by due process apply to civil commitment proceedings for juveniles.

*Amicus curiae,* Division of Mental Health Advocacy, supports appellees' contention before this Court that the findings and judgment of the court below should be affirmed insofar as they rectify certain constitutional deficiencies in a statutory commitment scheme such as that in effect in Pennsylvania.[50] Clearly, the state must provide substantial procedural protections to individuals facing involuntary civil commitment, to prevent the occurrence of erroneous confinements, *Specht* v. *Patterson,* 386 U. S. 605, 608 (1967); *Lynch* v. *Overholser,* 369 U. S. 705, 735 (1962). This Court has consistently reaffirmed this principle in affording persons confined to mental institutions protection of their constitutional rights. *O'Connor* v. *Donaldson,* 422 U. S. 563 (1975); *McNeil* v. *Director, Patuxent Institute,* 407 U. S. 245 (1972); *Humphrey* v. *Cady,* 405 U. S. 504 (1972); *Jackson* v. *Indiana,* 406 U. S. 715 (1972); *Baxstrom* v. *Herold,* 383 U. S. 107 (1966); *Specht* v. *Patterson, supra.*

Moreover, courts confronted with the issue of procedural protections for juveniles in commitment matters, have held the juveniles entitled to such protections, *Kidd* v. *Schmidt,* 399 F. Supp. 301 (E.D. Wis. 1975); *Saville* v.

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[49] Stone, *supra,* at 59, makes approving reference to a similar list of attorney functions prepared by Cohen, 44 *Tex. L. Rev., supra,* similar to the ones suggested by Ellis, and notes:

> Surely, some of the aforementioned functions are social service roles which far transcend what has traditionally been viewed as the attorney's function, but if the attorney does not fill some of these needs, it is unlikely that anyone else will; and without aid of counsel, commitment can easily become a summary or self-fulfilling process. There are, increasingly, lawyers who understand and are willing to fill these needs. And if counsel come to be perceived as co-workers in the mental health system, dedicated to the aforementioned array of purposes, and not merely as righteously contentious obstructors, their presence during the commitment process will be welcomed rather than dreaded.

See also, Stone, *supra,* at 233-237.



[50] It is the understanding of *amicus* that certain amendments to the Pennsylvania Mental Health and Mental Retardation Act (50 *P.S.* §§ 4402, 4403) concerning commitment proceedings of juveniles have recently been passed by the Pennsylvania Legislature. The apparent effect of these amendments (Senate Bill 1025) is (1) to lower from 18 to 14 the age at which a juvenile may voluntarily apply for admission to treatment under the Act, (2) to permit the parent, guardian, or person *in loco parentis* of a minor between the ages of 14 and 18 to object to such an application, and (3) to permit "any responsible party" to petition, on behalf of a minor under the age of 14 in voluntary treatment, for withdrawal from or modification of such treatment, whereupon an attorney is to be appointed for the minor and a hearing held within ten days of receipt of the petition, to determine what inpatient treatment, if any, is in the minor's best interest. The amended act apparently makes no changes in commitment procedures for mentally ill juveniles under 14 years of age. Furthermore, the amendments have no effect whatsoever on commitment proceedings for mentally retarded juveniles.

*Treadway,* 404 F. Supp. 430 (M.D. Tenn. 1974); *Heryford* v. *Parker,* 396 F. 2d 393 (10 Cir. 1968). The likelihood of confinement compels the imposition of strict procedural protections, *In re Gault,* 387 U. S. 1 (1967); nor does the fact that the commitment is geared towards rehabilitative ends, and not for punitive purposes, obviate the need for such procedural scrutiny, *cf. Breed* v. *Jones,* 421 U. S. 519 (1975). The protections ensured by the court below in the name of constitutional due process guarantees should be reaffirmed by this Court.

**A. The right to counsel.**

The necessity for legal representation—including the right to appointed counsel where an individual, for any reason, is unable to retain his own—in proceedings which attempt to deprive an individual of his liberty has long been recognized by courts throughout the country. The United States Supreme Court has consistently vindicated this right in a line of cases dating from *Powell* v. *Alabama,* 287 U. S. 45 (1932), to *Argersinger* v. *Hamlin* 407 U. S. 25 (1972). Beginning with the premises that "the right to be heard would be, in many cases, of little avail if it did not comprehend the right to be heard by counsel," *Powell,* 287 U. S., *supra* at 69, the Supreme Court reaffirmed that basic right in criminal felony proceedngs, *Gideon* v. *Wainwright,* 372 U. S. 335 (1963), in juvenile delinquency proceedings, *In re Gault, supra,* and in trials for petty offenses, *Argersinger,* 407 U. S., *supra,* at 37.

Drawing, in part, on the precedents established in the context of criminal proceedings, a number of courts have undertaken an examination and enumeration of due process guarantees attaching to the civil commitment process. A review of those cases indicates that the right to counsel



is clearly emerging as a fundamental prerequisite to the constitutionality of such proceedings. In *Lessard* v. *Schmidt,* 349 F. Supp. 1078 (E.D. Wis. 1972), vacated on other procedural grounds 414 U. S. 473 (1974), on remand 379 F. Supp. 1376 (E.D. Wis. 1974), vacated and remanded on other grounds 421 U. S. 957 (1975), the original three-judge district court held unconstitutional a state statutory civil commitment scheme similar to that of Pennsylvania, and mandated a panoply of rights and protections to be enforced in civil commitment proceedings, including: timely notice of "charges"; a speedy hearing on final disposition; exclusion of hearsay evidence; privilege against self-incrimination; notice of rights, including right to a jury trial; and the right to representation by counsel at the hearing. In treating the right to counsel specifically, the *Lessard* Court held: "We agree that the importance of the interests involved makes imperative the assistance of counsel as soon after proceedings are begun as is realistically feasible." *Lessard I,* 349 F. Supp., *supra* at 1099. The judicial foundation on which the *Lessard* Court established the constitutional right included *Powell, Argersinger,* and *Gault,* all *supra. Id.* at 1098.

In *Heryford* v. *Parker, supra,* the court was confronted with a *habeas corpus* petition by a mother on behalf of her nine-year-old son who had been committed to the Wyoming State Training School for the feeble-minded and epileptic. The three-judge panel held that due process required the appointment of counsel at a hearing aimed at the involuntary commitment of a mentally deficient indigent individual. The *Heryford court* specifically rejected the "civil/criminal" distinction, focusing instead on the likelihood of involuntary confinement as the basis for the right.

> Where, as in both proceedings for juveniles and mentally deficient persons, the state undertakes to act in *parens patriae,* it has the inescapable duty to vouchsafe due process, and this necessarily includes the duty to see that a subject of an involuntary commitment proceeding is afforded the opportunity to the guiding hand of legal counsel at every step of the proceedings, unless effectively waived by one authorized to act in his behalf. 396 F. 2d at 396.

*Dixon* v. *Attorney General of Pennsylvania,* 325 F. Supp. 966 (M.D. Pa. 1971) was a class action brought by inhabitants of a state hospital attacking the constitutionality of various provisions of the state civil commitment law. In finding that the challenged law violated due process in several regards, the court expressly ordered, with respect to all further involuntary commitment proceedings, that "[t]he subject thereof shall be informed of his right to counsel and an attorney shall be appointed to represent him unless he can afford to retain an attorney himself." 325 F. Supp. at 974. Other courts have reached the same result and, in so doing, have also rejected the *parens patriae* doctrine and the "civil/criminal" distinction as justification for deprivation of the constitutional right to counsel in these proceedings. *In re Barnard,* 455 F. 2d 1370 (D.C. Cir. 1971); *Denton* v. *Commonwealth,* 383 S.W. 2d 681 (Ky. App. 1964); *State ex rel. Hawks* v. *Lazaro,* 202 S.E. 2d 109 (W. Va. Sup. Ct. App. 1974); *In re Fisher,* 39 Ohio St. 2d 71, 313 N.E. 2d 851 (Sup. Ct. 1974). See also, *State ex rel. Richey* v. *Superior Court,* 59 Wash. 2d 872, 371 P. 2d 51 (Sup. Ct. 1962). There are numerous other cases in which state and federal courts have found a constitutional right to representation by counsel in commitment proceedings and, where a person



cannot afford to retain counsel, to have counsel appointed. See, *e.g., In re Hayes,* 18 N.C. App. 560, 197 S.E. 2d 582 (Ct. App. 1973); *In re Collman,* 9 Ore. App. 476, 497 P. 2d 1233 (Ct. App. 1972); *In re Adams,* 497 P. 2d 1080 (Okla. Sup. Ct. 1972); *People* v. *Potter,* 85 Ill. App. 2d 151, 228 N.E. 2d 238 (App. Ct. 1967); *In re Popp,* 33 *Ohio* App. 2d 22, 292 N.E. 2d 330 (Ct. App. 1972). *Cf. McCorkle* v. *Smith,* 100 N. J. Super. 595, 242 A. 2d 861 (App. Div. 1968), and *In re Geraghty,* 68 N. J. 209, 343 A. 2d 737 (1975).

The net effect of the holdings in these cases is the judicial determination that the right to counsel in civil commitment proceedings is of the same constitutional magnitude as that right in criminal proceedings. Whether the purpose of the confinement be therapeutic or punitive, whether the proceeding is labeled "civil" or "criminal", whether the state claims to act in the name of *parens patriae* or in the name of its police power, due process demands that an individual facing involuntary commitment be afforded the opportunity to consult with and rely on legal counsel.[51]

**B. The right to notice.**

It is axiomatic that due process mandates that adequate notice and an opportunity to be heard by given to individuals before the state may deprive them of their liberty and property, *Mullane* v. *Central Hanover Bank,* 339 U. S. 306 (1950), that this notice be sufficient to give the recipient "reasonable opportunity to prepare" and set forth the basis for any detention, *In re Gault,* 387 U. S., *supra*

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[51] For a further discussion of the practical effects of providing counsel at involuntary commitment proceedings, see Point II, *supra.*

at 33, and that it be sufficiently specific to inform the recipient of the character of the proceedings and the issues in question, *Goldberg* v. *Kelly,* 397 U. S. 254, 267-268 (1970). See also, *Morrisey* v. *Brewer,* 408 U. S. 471, 488-489 (1972) (notice at parole revocation hearing); *Gagnon* v. *Scarpelli,* 411 U. S. 778 (1973) (probation revocation hearings); *Wolff* v. *McDonnell,* 418 U. S. 539 (1974) (prison disciplinary hearings); *Fuentes* v. *Shevin,* 407 U. S. 67 (1972), reh. den. 409 U. S. 902 (1972); *Avant* v. *Clifford,* 67 N. J. 496, 341 A. 2d 629 (1975); *State* v. *Holmes,* 109 N. J. Super. 180, 183, 262 A. 2d 725 (Law Div. 1970).

In an analogous situation, state statutes similar to the one under consideration were struck down by a three-judge Federal District Court as being violative of due process. In the lead case of *Lessard* v. *Schmidt, supra,* a set of Wisconsin statutes permitting temporary involuntary confinement without a judicial hearing was declared unconstitutional because of the "significant deprivation of liberty" involved in a "16 or 26 day" period of confinement; there, the court relied heavily on *Boddie* v. *Connecticut,* 401 U. S. 371, 379 (1971), which held that an individual must "be given an opportunity for a hearing before he is deprived of any significant property interest . . .," noting that an individual's interest in liberty is "even more compelling" than in property rights, *Lessard I,* 349 F. Supp., *supra* at 1091; *Lessard II,* 379 F. Supp., *supra* at 1378-1379. Further, *Lessard* extended the notice requirement beyond the factual basis of the allegations, to encompass, *inter alia,* the patient's right to a jury trial, the standards for detention, the names of witnesses testifying in support of detention, and the substance of their proposed testimony. *Lessard I,* 349 F. Supp., *supra* at 1092; *Lessard II, supra.*



As noted by the District Court in the instant case, written notice ("including the date, time, and place of the hearing, and a statement of the grounds for the proposed commitment") is constitutionally required and "should not shield children in need of institutionalization from commitment and treatment but rather should protect children not in need of institutionalization from wrongful commitment and improper deprivation of their liberty." *Bartley* v. *Kremens,* 402 F. Supp. 1039, 1050 (E.D. Pa. 1975).

**C. The right to be present at the hearing.**

The due process right to be present at any hearing in which a deprivation of some right may result is a well-established principle of constitutional law, *Goldberg* v. *Kelly,* 397 U. S., *supra* at 268-269, and this principle has specifically been invoked to require the presence of the person subject to commitment at all judicial proceedings conducted for that purpose, *Specht* v. *Patterson,* 386 U. S., *supra* at 610; *Lessard I,* 349 F. Supp., *supra,* and *Lessard II,* 379 F. Supp., *supra; Bell* v. *Wayne County General Hospital,* 384 F. Supp. 1085, 1094 (E.D. Mich. 1974); *Lynch* v. *Baxley,* 386 F. Supp. 378, 388-389 (M.D. Ala. 1974); *State ex rel. Hawks* v. *Lazaro,* 202 S.E. 2d, *supra* at 125.

This right should be absolute, unless (1) the patient wishes to knowingly, voluntarily and intelligently waive his right to be present (see, *e.g., Johnston* v. *Zerbst,* 304 U. S. 458 (1938)), or (2) the patient is so continually and persistently disruptive that the hearing cannot be conducted. These are the only legitimate reasons for barring a criminal defendant from his own trial, *Illinois* v. *Allen,* 397 U. S. 337, 342-343 (1970), reh. den. 398 U. S. 915

(1970), and should be the only ones to justify exclusion at a commitment hearing. *Bell* v. *Wayne County General Hospital, supra; Lynch* v. *Baxley, supra;* Singer, "Civil Commitment Proceedings: A Response to 'A Trial Judge's View' ", 98 *N. J. L. J.* 553, 568 (June 26, 1975);[52] see generally, "Developments," 87 *Harv. L. Rev., supra* at 1282-1283.

The court below specifically adopted the *Lynch* v. *Baxley* procedure as appropriate, in holding that "a child has a constitutional right to be present at all hearings concerning his proposed commitment," subject to waiver under certain specified conditions. 402 F. Supp., *supra* at 1051.

**D. Rights at the commitment hearing.**

It has, of course, long been axiomatic that a criminal defendant is constitutionally entitled to cross-examine and confront witnesses against him, *Pointer* v. *Texas,* 380 U. S. 400, 406 (1965). It should be equally apparent that these rights are applicable to involuntary commitment proceedings, *Specht* v. *Patterson, supra; Millard* v. *Harris,* 406 F. 2d 964, 973 (D.C. Cir. 1968); *Lynch* v. *Baxley,* 386 F. Supp., *supra* at 394; *State ex rel. Hawks* v. *Lazaro,* 202 S.E. 2d, *supra* at 124-125; *Dixon* v. *Attorney General of Pennsylvania,* 325 F. Supp., *supra* at 972, 974; *People* v. *English,* 31 Ill. 2d 301, 201 N.E. 2d 455, 458 (Sup. Ct.

[52] *Cf.* N. J. Ct. R. 4:74-7(e): "The patient shall be required to appear at the hearing, but may be excused from the courtroom upon application for good cause shown. Good cause shall include testimony by the psychiatrist that the mental condition of the patient would be adversely affected by the patient hearing his candid and complete testimony."



1964); see also *In re Gault,* 387 U. S., *supra,* at 10. If a plenary hearing is to have any meaning, and if the court is to make a knowing and intelligent determination of the question of mental illness based on intensive scrutiny of the fullest possible proofs, then due process requires a statutory scheme which ensures the right to be heard—both through one's own witnesses and evidence, *Dixon* v. *Attorney General of Pennsylvania,* 325 F. Supp., *supra* at 974, and through confrontation of witnesses and evidence offered in support of commitment, *Lynch* v. *Baxley,* 386 F. Supp., *supra* at 394. The holding of the court below along these lines should be affirmed.

**E. The standard of proof.**

On the question of standard of proof, *amicus* respectfully takes issue with the lower court's determination that "clear and convincing proof" is sufficient. The very principles which that court cites, concerning the highly subjective nature of the evidence in commitment proceedings, the potential loss of liberty, and the stigmatization likely to result from institutionalization, would reasonably mandate the highest standard possible. It is interesting to note that *Lynch* v. *Baxley, supra*—cited by the lower court in support of the "clear and convincing" standard—calls for "clear, *unequivocal,* and convincing evidence that the subject is in need of confinement . . ." 386 F. Supp. at 393 (emphasis added), indicating that something higher than "clear and convincing" proof is required. Clearly, proof beyond a reasonable doubt is the most unequivocal of standards; certainly the quantum of proof it

requires is more compelling than that of clear and convincing evidence.[53]

---

[53] The current standard of proof for commitments in New Jersey apparently is "a preponderance of the evidence." The New Jersey Supreme Court adopted this standard for civil commitments of defendants acquitted of criminal charges by reason of insanity. *State* v. *Krol*, 68 N. J. 236, 257, 344 A. 2d 289, 301 (1975). In imposing this lower standard, the court acknowledged the "trend in recent cases to require a burden of proof in civil commitment cases greater than simple preponderance of the evidence [citations omitted]," 68 N. J. at 257, 344 A. 2d at 301, n. 9, and supported its holding by reference to recent cases which hold that "a standard of preponderance of the evidence is sufficient *for commitment of persons acquitted by reason of insanity.*" *Id.* (emphasis added). In imposing this standard in the context of civil commitments of criminal defendants acquitted by reason of insanity, the majority opinion in *Krol* refers to, and apparently incorporates, the use of the "preponderance" standard to prove insanity at the time of the commission of the offense. It may well be argued that the use of the "preponderance" standard in the prior proceeding (resulting in an acquittal with a finding of insanity) accounts for its use in the subsequent civil commitment proceeding envisioned by the *Krol* majority. In this context, note the discussion by Justice Clifford, in dissent:

> The difficulty in making the critical determination, that defendant is mentally ill, and poses a danger to himself or society if not restrained, militates in favor of the higher burden of proof beyond a reasonable doubt to reduce the substantial opportunity for error particularly when as here, the consequence of that error is loss of liberty.
>
> 68 N. J. at 267, 275, 344 A. 2d at 306, 310 (Clifford, J. dissenting)

Insofar as the standard of proof issue has been considered by New Jersey courts in the context of civil commitment proceedings outside the criminal sphere, the standard of beyond a reasonable doubt has been applied. *In re Heukelekian*, 24 N. J. Super. 407, 94 A. 2d 501 (App. Div. 1953); *In re Perry*, 137 N. J. Eq. 161, 43 A. 2d 885 (1945). *Amicus* submits that this standard is warranted in the interest of preventing wrongful institutionalization of individuals (particularly juveniles) whose confinement is sought solely on an allegation, often highly subjective in nature, of mental illness. See, *e.g.*, "Developments", 87 *Harv. L. Rev.*, *supra* at 1302.



## CONCLUSION

**On the basis of the foregoing, it is respectfully submitted that the judgment and decree of the District Court should be affirmed.**

Respectfully submitted,

STANLEY C. VAN NESS
Public Advocate
State of New Jersey
By: MICHAEL L. PERLIN, Director
LAURA M. LE WINN, Deputy Director
*Department of the Public Advocate*
*Division of Mental Health Advocacy*
10-12 North Stockton Street
Trenton, New Jersey 08625
*Amicus Curiae*

Dated: July 23, 1976

[APPENDIX FOLLOWS]

# APPENDIX

**Letter of Barry A. Roth, Assistant Attorney General, Commonwealth of Pennslyvania to David Ferleger, Esq., Attorney for Appellees, dated May 11, 1976**

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
HARRISBURG, PENNSYLVANIA 17120

May 11, 1976

David Ferleger, Esquire
Mental Patient Civil Liberties Project
Suite 1600, 1315 Walnut Street
Philadelphia, Pa. 19107

Re: *Kremens et al.* v. *Bartley et al.*

Dear David:

I have reviewed your May 3, 1976 letter with specific regard to your request to have the following groups participate as *amicus* for which you seek my written consent. Accordingly, you are advised that I consent to participation of the Mental Health Law Project (representing American Psychological Association, National Association for Retarded Citizens, New York Federation of Parents, American Orthopsychiatric Organization); Youth Law Center and Childrens' Defense Fund; National Center for Law and the Handicapped; and the New Jersey Department of the Public Advocate. I await your written consent to participation of the Allegheny Valley Schools.

As always, I shall provide written consent for any reasonable request for responsible amicus to participate in this case as I expect you will do the same.

Very truly yours,

BARRY A. ROTH
Assistant Attorney General

cc: NORMAN WATKINS, Esq.

## Memorandum No. 4-74 of Hon. Richard J. Hughes, Chief Justice of the Supreme Court of New Jersey, dated November 12, 1974

SUPREME COURT OF NEW JERSEY

RICHARD J. HUGHES
Chief Justice

State House Annex
Trenton, New Jersey

# 4—74

November 12, 1974

MEMORANDUM TO: All Assignment Judges, Trial Court Administrators and County Clerks

FROM: Chief Justice Richard J. Hughes

RE: Involuntary Civil Commitment Proceedings

A study recently conducted by the Administrative Office of the Courts indicates that there is a lack of uniformity among the counties in regard to the docketing procedures being followed in civil commitment cases A great divergence of practice occurs in involuntary proceedings, where in many instances, papers are not filed until after the final judgment of commitment (See N.J.S.A. 30:4-56). In addition, lack of adequate docketing procedures has permitted uncontrolled administrative adjournments so the court does not have a written record of the patient's confinement. When notice is filed in the County Clerk's Office, no docket number has been assigned for further control.

In order to standardize procedures throughout the State, all involuntary civil commitment cases shall be handled in the manner described below.



*Memorandum No. 4-74 of Hon. Richard J. Hughes, Chief Justice of the Supreme Court of New Jersey, dated November 12, 1974*

1. DOCKETING

It shall be the responsibility of the Assignment Judge, either personally or through his Trial Court Administrator, to generally supervise the docketing of all involuntary civil commitment proceedings.

Assignment Judges shall arrange with all hospital facilities in their respective vicinages, so that within 72 hours of accepting a person for treatment, they will have forwarded written notification of this acceptance to the following: the County Clerk; the County Adjuster; the patient; and the patient's nearest relative. The Department of Institutions and Agencies will be contacting all state-run facilities directing them to forward notification in the prescribed manner.

Upon receipt of the above notification, it shall be the obligation of the County Clerk to docket the matter in the County Court. All such proceedings shall be docketed according to county, and in the following manner:

| *County* | *Code* | *Case Number* | *Year Committed* |
|---|---|---|---|
| Atlantic | ATCC | 1 | 74 |
| Bergen | BECC | 1 | 74 |
| Burlington | BUCC | 1 | 74 |
| Camden | CACC | 1 | 74 |
| Cape May | CMCC | 1 | 74 |
| Cumberland | CUCC | 1 | 74 |

*Memorandum No. 4-74 of Hon. Richard J. Hughes, Chief Justice of the Supreme Court of New Jersey, dated November 12, 1974*

| *County* | *Code* | *Case Number* | *Year Committed* |
|---|---|---|---|
| Essex | ESCC | 1 | 74 |
| Gloucester | GLCC | 1 | 74 |
| Hudson | HDCC | 1 | 74 |
| Hunterdon | HNCC | 1 | 74 |
| Mercer | MECC | 1 | 74 |
| Middlesex | MICC | 1 | 74 |
| Monmouth | MNCC | 1 | 74 |
| Morris | MRCC | 1 | 74 |
| Ocean | OCCC | 1 | 74 |
| Passaic | PACC | 1 | 74 |
| Salem | SACC | 1 | 74 |
| Somerset | SOCC | 1 | 74 |
| Sussex | SUCC | 1 | 74 |
| Union | UNCC | 1 | 74 |
| Warren | WACC | 1 | 74 |

Consequently, "ATCC 1-74" would refer to the first civil commitment case docketed in Atlantic County in the calendar year 1974.[1]

---

[1] Cases shall be docketed on a calendar year, rather than court year, basis. This conforms with the practice now prevalent in the county courts.



*Memorandum No. 4-74 of Hon. Richard J. Hughes, Chief Justice of the Supreme Court of New Jersey, dated November 12, 1974*

2. Assignment of Cases

Assignment Judges shall be given full discretion to assign civil commitment cases.

3. Scheduling of Cases

It shall be the responsibility of the County Clerk to assure that civil commitment hearings on the final order are held within 20 days from the date of initial commitment.

4. Written Notification of Hearing

It shall be the responsibility of the County Clerk to forward written notification of the time and place of the final hearing to the following: the County Adjuster; any assigned or retained counsel for the patient; the patient's nearest relative; and the plaintiff. Written notification shall be served personally upon the patient in accordance with N.J.S.A. 30:4-41.

In all instances mentioned above, written notification shall be transmitted no later than 5 days prior to the date of the hearing.

5. Adjournment Policy

It shall be the responsibility of the Assignment Judge to effectuate either a judgment of commitment or release of the patient as expeditiously as possible; therefore, in the absence of extraordinary circumstances there shall be no more than one adjournment, which shall only be

*Memorandum No. 4-74 of Hon. Richard J. Hughes, Chief Justice of the Supreme Court of New Jersey, dated November 12, 1974*

granted for good cause shown, and the duration of which should not exceed 10 days. If more than one adjournment is granted, a copy of the Order Granting Adjournment, with reasons therefore, shall be forwarded to the Division of Civil Practice, Administrative Office of the Courts, attention Cynthia Jacob.

6. Change in Patient's Status

Assignment Judges shall arrange with all hospital facilities in their respective vicinages to have the medical director or chief of service of said hospitals forward timely notification (which shall be construed as no less than 72 hours if a court hearing has been scheduled) of any substantive change in status to the following: the County Clerk; the County Adjuster; any assigned or retained counsel who may have represented the patient at the last review; the patient's nearest relative; and the plaintiff. Substantive change shall include, but not be limited to: death; discharge; transfer; unauthorized departure; conditional release and return therefrom.

7. Periodic Review

a. It shall be the responsibility of the Assignment Judge to supervise the periodic review of all persons who are now, or may hereafter become, involuntarily committed in their vicinage. For such purposes, docket numbers shall be assigned in the manner described above, with the last two digits reflecting the calendar year of initial commitment.



*Memorandum No. 4-74 of Hon. Richard J. Hughes, Chief Justice of the Supreme Court of New Jersey, dated November 12, 1974*

For all cases initiated after the effective date of this order, the following schedule shall be adopted:

1. A review of the proceedings 6 months after the date of final commitment.
2. A review of the proceedings 12 months after the date of final commitment.
3. A review of the proceedings 18 months after the date of final commitment.
4. A review of the proceedings 30 months after the date of final commitment.
5. A review of the proceedings every two years thereafter.

b. In all cases in which the patient had already been committed prior to the effective date of this order, the following schedule shall be adopted:

1. All patients committed 10 years or more shall have their cases docketed and reviewed by March 1, 1975 with a further review every 2 years from the date of the last review.
2. All patients committed 5-10 years shall have their cases docketed and reviewed by June 1, 1975, with a further review every 2 years from the date of the last review.
3. All patients committed 30 months to 5 years shall have their cases docketed and reviewed by September 1, 1975, with a further review every 2 years from the date of the last review.

*Memorandum No. 4-74 of Hon. Richard J. Hughes, Chief Justice of the Supreme Court of New Jersey, dated November 12, 1974*

4. All patients committed less than 30 months shall be reviewed in accordance with paragraph (a) of this section.[2]

It shall be the obligation of the County Clerk to assure that proper notification of the review shall be given to: the County Adjuster; the executive director or chief of service of the hospital in which the patient is confined; the patient; any assigned or retained counsel for the patient; the patient's nearest relative; and the plaintiff.

Unless requested by any of the parties mentioned in the preceding paragraph, it shall remain within the court's discretion whether to accomplish the review summarily or by means of a plenary hearing; however, if specifically requested, a hearing shall be scheduled.

8. Patient's Right to Appear

It shall be the responsibility of the Assignment Judge to assure that in all instances in which a hearing has been scheduled, that the patient be given every opportunity to appear. If the medical director or chief of service of the mental hospital feels that in his expert opinion it would be prejudicial to the health of the patient, or unsafe to produce the patient at the inquiry, then it shall be the obligation of the medical director or chief of serv-

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[2] Officials at the Department of Institutions and Agencies have assured us that they presently are preparing an internal review of each patient's status on a semi-annual basis. Accordingly, there will be no administrative burden placed upon the institutions themselves in complying with this section of the Directive.



*Memorandum No. 4-74 of Hon. Richard J. Hughes, Chief Justice of the Supreme Court of New Jersey, dated November 12, 1974*

ice to certify in writing to the court his expert opinion concerning the patient's inability to appear, setting forth the facts supporting his conclusion. The hearing judge shall evaluate any certification submitted and determine whether the personal appearance of the patient is feasible. (See N.J.S.A. 30:4-41).

The policy and procedures set forth in this memorandum shall take effect immediately.

cc: County Counsels

County Adjusters

Department of Institutions and Agencies

## New Jersey Court Rule 4:74-7

4:74-7. Civil Commitment

(a) Definitions. The definitions contained in N.J.S.A. 30:4-23 apply to this rule. The classes "A," "B," and "C" referred to in this rule are those defined by N.J.S.A. 30:4-36 to 30:4-38 inclusive. The term "patient" used in these rules means the person whose commitment is sought pursuant to said statutes. The term "psychiatrist" used in these rules means a licensed physician of the State of New Jersey, who shall be either certified or eligible for certification by the American Board of Neurology and Psychiatry.

(b) Commencement of Action. An action for commitment shall be commenced by the filing of a written application, signed by the person seeking the commitment, to which shall be attached the typewritten certificates of two licensed physicians of the State of New Jersey. The certificates shall state with particularity the facts upon which the physician relies in concluding that the patient if not committed would be a probable danger to himself or the community. The form of application shall be prescribed by the Department of Institutions and Agencies subject to the approval of the Administrative Director of the Courts.

(c) Temporary Commitment. A temporary commitment may be ordered based on the application provided for in paragraph (b) of this rule. The order of temporary commitment shall make the following provisions:

1. A place and day certain shall be set for the commitment hearing, which shall be in Class "A" cases not more





than 20 days from the filing of the application, in Class "B" cases not more than 20 days from the date of the temporary order of commitment, and in Class "C" cases not more than 20 days from the date of admission of the patient into the institution. The date shall not be subject to adjournment except that in exceptional circumstances and for good cause shown in open court and on the record the hearing may be adjourned for a period of not more than 10 days.

2. If the patient is unrepresented, the temporary commitment order shall assign counsel to represent him. If the patient is a minor, a guardian ad litem shall be appointed who shall be an attorney. If the court, for good cause shown, appoints a guardian ad litem who is not an attorney, counsel for the guardian ad litem shall also be appointed. Assigned counsel and guardian ad litem fees shall be fixed by the court after hearing and paid pursuant to paragraph (h) of this rule.

3. The persons to be notified of the time and place of hearing, the mode of service of the notice, and the time within which notice must be served shall be specified. In no case, however, shall notice be served less than 10 days prior to the date of the hearing, nor shall any mode of service of the notice on the patient be permitted other than personal service. In addition to the patient and his counsel or guardian ad litem, notice shall also be given to the applicant, the nearest relatives of the patient, the county adjuster, and where the patient is confined to an institution, the superintendent of the institution. Notice may be further ordered to be served on any other person specified by the court.

(d) Discovery. Any rule, regulation or policy of confidentiality notwithstanding, the patient's counsel or guardian ad litem shall have the right to inspect and copy all records relating to the patient's mental condition. The court may direct an independent psychiatric examination of the patient. The cost of said examination and the psychiatrist's fee for testifying, if any, shall be borne by the person or public body charged with the patient's legal settlement.

(e) Hearing. No permanent commitment order shall be entered except upon hearing conducted in accordance with provisions of these rules. The application for commitment shall be supported by the oral testimony of at least one licensed psychiatrist of the State of New Jersey, who shall have conducted at least one examination of the patient subsequent to the date of the temporary order. The patient shall be required to appear at the hearing, but may be excused from the courtroom during all or any portion of the testimony upon application for good cause shown. Good cause shall include testimony by the psychiatrist that the mental condition of the patient would be adversely affected by the patient hearing his candid and complete testimony. The patient shall have the right to testify in his own behalf but need not. The hearing shall be held in camera unless good cause to the contrary is shown. The applicant for the commitment may appear either by counsel retained by him or by the county adjuster. In no case shall the patient appear pro se.

(f) Final Judgment of Commitment, Review. If the court finds from the evidence presented at the hearing that the institutionalization of the patient is required by



reason of his being a danger to himself or the community if he is not so confined and treated, it shall enter a judgment of commitment to an appropriate institution. The judgment shall provide for review of the commitment no later than (1) six months from the date of judgment, and (2) on or before one year from the date of judgment, and (3) annually thereafter, if the patient is not sooner discharged. All reviews shall be conducted in the manner required by paragraph (e) of this rule.

(g) Judgment of Release. A judgment discharging the patient may contain in appropriate circumstances conditions for the release such as attendance at a non-residential mental health facility or other form of supervision. Any such conditions shall be stated in the order of discharge with particularity. The continuation of any such conditions shall be subject to periodic review as provided by paragraph (f) hereof.

(h) Legal Settlement. The patient's legal settlement providing for the payment of the expense of his care and treatment shall be considered either at the commitment hearing or at a hearing on notice which may be held by the county adjuster thereafter and reported to the court. In either case the settlement shall be on order of the court. The person or public body charged with the legal settlement shall also be charged with the fee of assigned counsel and guardian ad litem and necessary costs incurred by him in representing the patient. If the assigned counsel or guardian ad litem is employed by a legal services project, his fee shall be ordered payable thereto. If he is employed by the State or a county, no fee allowance shall be made.

*New Jersey Court Rule 4:74-7*

i) Filing. All documents referred to in this rule shall be filed in the County Clerk's office together with an affidavit of service of all notices herein required. The files of the County Clerk shall not, however, be open to inspection by any person other than assigned counsel, guardian ad litem and the county adjuster except on court order in exceptional circumstances and for good cause shown.

(j) Commitments of Minors. No minor shall be committed except temporarily to a mental institution for treatment and care of an alleged mental condition on the application of his parent or parents or other person in loco parentis except on court order after hearing pursuant to paragraph (e) hereof. A guardian ad litem who shall be a person other than the applicant for the commitment, shall be appointed by the court to represent the interests of the minor at such hearing.



**Memorandum from David Ferleger, Esq. Certifying Consent of Plaintiffs-Appellees to the Filing of Briefs by *Amici Curiae*, dated July 21, 1976**

David Ferleger Attorney
2321 Sansom Street
Philadelphia, Pennsylvania 19103
(215) 735-8409, 567-2828

July 21, 1976

To: Counsel for Amici in *Kremens* v. *Bartley*, No. 75-1064 (Sup.Ct.)

From: David Ferleger, Esq.

Subject: Consent to Filing of Briefs

This is to certify the consent of plaintiffs-appellees to the filing of briefs amicus curiae in the above case by the following organizations and counsel:

American Bar Association

Youth Law Center

National Juvenile Law Center

Department of the Public Advocate, State of New Jersey

Children's Defense Fund (for plaintiffs in various cases)

Mental Health Law Project (for American Psychological Association, National Association for Mental Health, National Association for Retarded Citizens, National Association of Social Workers, New York Federation of Parents Organizations in New

*Memorandum from David Ferleger, Esq. Certifying Consent of Plaintiffs-Appellees to the Filing of Briefs by Amici Curiae, dated July 21, 1976*

York, National Center on Law and the Handicapped, American Orthopsychiatric Association, United Cerebral Fund)

Michigan Legal Services and Legal Services for Western Michigan (for plaintiffs in Michigan cases)

New York State Bar Association

This consent may be filed in the Supreme Court with your brief which as you know is due by August 4, 1976.

Thank you for your assistance in this matter.

DAVID FERLEGER

Supreme Court, U. S.
FILED
AUG 3 1976
MICHAEL RODAK, JR., CLERK

IN THE

# Supreme Court of the United States

No. 75-1064

JACK B. KREMENS, *et al.*,
*Appellants*

v.

KEVIN BARTLEY, *et al.*,
*Appellees*

**Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania**

## BRIEF OF AMERICAN ORTHOPSYCHIATRIC ASSOCIATION, AMERICAN PSYCHOLOGICAL ASSOCIATION, FEDERATION OF PARENTS ORGANIZATIONS FOR THE NEW YORK STATE MENTAL INSTITUTIONS, NATIONAL ASSOCIATION FOR MENTAL HEALTH, NATIONAL ASSOCIATION FOR RETARDED CITIZENS, NATIONAL ASSOCIATION OF SOCIAL WORKERS AND NATIONAL CENTER FOR LAW AND THE HANDICAPPED AS *AMICI CURIAE* IN SUPPORT OF APPELLEES

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IN THE

# Supreme Court of the United States

OCTOBER TERM, 1976

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No. 75-1064

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JACK B. KREMENS, *et al.*,
*Appellants*

v.

KEVIN BARTLEY, *et al.*,
*Appellees*

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**Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania**

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## BRIEF OF AMERICAN ORTHOPSYCHIATRIC ASSOCIATION, AMERICAN PSYCHOLOGICAL ASSOCIATION, FEDERATION OF PARENTS ORGANIZATIONS FOR THE NEW YORK STATE MENTAL INSTITUTIONS, NATIONAL ASSOCIATION FOR MENTAL HEALTH, NATIONAL ASSOCIATION FOR RETARDED CITIZENS, NATIONAL ASSOCIATION OF SOCIAL WORKERS AND NATIONAL CENTER FOR LAW AND THE HANDICAPPED AS *AMICI CURIAE* IN SUPPORT OF APPELLEES

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## INTEREST OF *AMICI CURIAE*

*Amici curiae* are seven organizations of mental health and mental retardation professionals and parents of

children with emotional and developmental handicaps concerned with the legal rights and effective delivery of services to these children and adolescents.[1]

Collectively, *amici* have a strong commitment to the delivery of high quality mental health and retardation services to children and adolescents. They believe that whenever possible such services should be administered on a voluntary basis in the community. Children and adolescents are generally best treated and cared for by their own families in their normal surroundings rather than by segregation in institutions for the mentally ill or retarded. Moreover, *amici* believe that in the great majority of cases such non-institutional treatment or

[1] Henceforth in this Brief, *amici* will include

(1) The American Orthopsychiatric Association, an interdisciplinary organization of 4,000 members including psychiatrists, psychologists, social workers, educators and allied professionals concerned with the problems, causes and treatment of abnormal behavior;

(2) The American Psychological Association, composed of 40,000 psychologists, which addresses, among other things, issues involving health and education service delivery to juveniles and others;

(3) The Federation of Parents Organizations for the New York State Mental Institutions, an organization of 30,000 parents, relatives and citizens concerned with the treatment of patients in New York Department of Mental Hygiene facilities;

(4) The National Association for Mental Health, a citizens organization of one million lay and professional members whose primary purpose is to encourage efforts to provide better services for the mentally ill;

(5) The National Association for Retarded Citizens, a voluntary organization devoted to promoting the welfare of mentally retarded children and adults with 300,000 adult members;

(6) The National Association of Social Workers, an organization of 70,000 professional social work members with chapters in 50 states devoted to the advancement of sound public policy for social work consumers as well as professionals;

(7) The National Center for Law and the Handicapped, established with HEW funding to provide legal assistance to promote the full social and legal integration of all disabled Americans.



training can be successful when families are given the community support and specialized help they need for their mentally handicapped children. Accordingly, the *amici* groups have worked for the creation of better and more diversified community based facilities and programs for the mentally ill and retarded. They have increasingly emphasized the need for such programs and facilities for disturbed and retarded children because they believe that appropriate and nonstigmatizing help in the early years provides the greatest opportunity for producing healthy and well functioning citizens.

*Amici* do not oppose institutionalization of children and adolescents in all cases. They recognize that some children have such severe illnesses or need such specialized services that residential care outside the family may be necessary. But they are concerned that children should not be removed from normal family, peer and community contacts without a formalized and searching inquiry into their needs. Although the majority of parents are normally conscientious advocates for their children, they are often beset by conflicts and confusion of their own and by apathy on the part of official agencies. Parents are often unaware of alternatives to institutionalization, when in fact their children might be treated in the community. Although *amici* are sensitive to the sometimes competing demands of due process and therapy, they believe that an accommodation can be accomplished and that the requirement of due process hearings in connection with the institutionalization of children and adolescents will confer genuine benefits on the child and the family.

*Amici* represent both mental health and mental retardation professionals—psychiatrists, psychologists and social workers—and parents, who deal on a day to day basis with the problems of emotionally disturbed and mentally retarded children and adolescents. This Brief

will inform the Court of studies and experience relevant to the question of how and when due process procedures should be applied to the commitment of children to institutions for the mentally ill or retarded.

*Amici* have received consent from both Appellants and Appellees to file this Brief.

## STATEMENT OF THE CASE

This class action was brought pursuant to 28 U.S.C. §§ 1331, 1343(3) and 42 U.S.C. § 1983 in the United States District Court for the Eastern District of Pennsylvania on behalf of all children eighteen years of age or younger admitted to mental health facilities under the Pennsylvania Mental Health and Mental Retardation Act, 50 Pa. Stat. Ann. § 4402 and § 4403. Under those sections, applications for "voluntary" admission or commitment of a child eighteen years or under to a mental facility[2] may be made by a "parent, guardian or individual standing *in loco parentis*" to the child. If the director of the facility, after examination of the child, determines the child "is in need of care or observation," the child may be admitted to the facility.

The minor plaintiffs alleged they were denied due process and equal protection of the law by Pennsylvania mental health officials under the Fourteenth Amendment to the United States Constitution because, unlike adults subjected to involuntary confinement, they were denied a hearing with prior notice, right to counsel, right to confront and cross-examine witnesses and the right to produce evidence against institutionalization.[3]

[2] Under Pennsylvania law in effect at the time of the decision, "facility" included "any mental health establishment, hospital, clinic, institution, daycare center or other organizational unit . . . devoted principally to the diagnosis, treatment, care, rehabilitation or detention of mentally disabled persons." 50 Pa. Stat. Ann. § 4102. Thus the decision of the court below applies to private as well as public residential facilities for the mentally ill and mentally retarded.



A three-judge court, convened pursuant to 28 U.S.C. § 2281, after receiving evidence about the circumstances under which the named plaintiffs were admitted to mental facilities and hearing expert testimony by several psychiatrists, ruled, one judge dissenting, that the "voluntary" admission and commitment procedures of Sections 4402 and 4403 were unconstitutional as they applied to

[3] Regulations issued by the Pennsylvania Department of Public Welfare, 3 Pa. Bull. 1840, subsequent to the filing of the action, required that prior to a child's admission to a mental facility under Sections 4402 and 4403, there must be a referral from a recognized medical facility, Mental Health/Mental Retardation therapist or Mental Health Agency (in the case of a mentally retarded child the referral might be from a pediatrician, general physician or psychologist). The referral must be accompanied by a psychiatric evaluation of the child or, in the case of a mentally retarded child, a medical or psychological evaluation along with a statement of the reasons why the child needs institutional care. In addition, the director of the facility must, after an independent examination, concur with the referring professional's decision that the child should be institutionalized. Within 24 hours of admission, a child thirteen years or older had to be notified in writing that he could contact his parents or guardian and that, if he objected to admission, he would be furnished with the telephone number of a lawyer whom he could call for representation. If a child thirteen years of age or older objected to staying in the facility, the director had either to agree to his release or arrange within two to four days for involuntary hospitalization proceedings to be filed under 50 Pa. Stat. Ann. § 4406. *See Bartley* v. *Kremens*, 402 F. Supp. 1039, 1042-1043 n. 5 (E.D. Pa. 1975).

On July 8, 1976, subsequent to the decision, the Governor of Pennsylvania signed into law Act No. 143, the Mental Health Procedures Act, which permits any child fourteen years of age or over who understands the nature of his action to volunteer for admission into a facility for the mentally ill. If he does not so volunteer, he can presumably be admitted only under the involuntary commitment procedures applicable to adults. A child under fourteen may still be volunteered by his parents, although any "responsible person" may file in juvenile court to effect his release or transfer to a less restrictive alternative. The Act does not appear to affect placements of children into mental retardation facilities.

children eighteen years old or younger. *Bartley* v. *Kremens*, 402 F. Supp. 1039 (E.D. Pa. 1975). The court rejected the defendants' argument that due process guarantees were inapplicable because the purpose of the "voluntary" admission statutes was to meet the child's needs through treatment rather than to punish or incarcerate him. Also rejected was defendants' argument that the state's "interest in protecting the child, preserving the family unit, maintaining the rights of parents to the custody, care, and upbringing of their children," justified the infringement of the child's liberties. 402 F. Supp. at 1045.

In ruling that due process must be accorded to children placed in mental facilities, the court reasoned that "[G]enerally, the state is required to provide substantial procedures where there is the possibility of erroneously and wrongfully depriving persons of their liberty by committing them to mental institutions." A child facing confinement for an indeterminate period in a mental facility is threatened with loss of a significant liberty and property interest cognizable under the Fourteenth Amendment. He may be "involuntarily removed from his home and familiar surroundings . . . committed to an institution where '[he] suddenly faces the regimented routine of ward life and daily confrontation with state employees, however capable, rather than family and friends.'" He faces "stigma . . . which . . . may render civil commitment a more lasting abridgement of personal freedom than imprisonment for commission of a crime." He is therefore entitled to a due process hearing if he wishes to oppose his institutionalization. 402 F. Supp. at 1045-1046.

The court further held that the minor's due process rights cannot be waived by a parent or guardian, because "[i]n deciding to institutionalize their children, parents, as well as guardians ad litem or persons standing in loco parentis, may at times be acting against the interests of their children." 402 F. Supp. at 1047-1048.



Finally, the court listed the elements of due process required for admission of a minor to a mental health facility. It did not require a hearing prior to admission because it did not wish to "deter parents, already faced with this difficult decision, from attempting to institutionalize children who are in need of treatment only mental institutions can provide" and because it recognized that "the state has an interest in the immediate detention of children who may be dangerous to themselves or others." It did require, however, that the child be seen by an attorney and advised of his rights promptly after admission. One such right was to have "a hearing before an unbiased tribunal . . . to test whether there is probable cause to believe institutionalization is necessary" within 72 hours from initial detention. Following a finding of probable cause, the child is entitled, within two weeks of initial detention, to a full evidentiary hearing on the necessity of his hospitalization.[4] Prior to both the probable cause and commitment hearings, the child and his attorney must be notified of the time, place and date of the hearing and the reasons for institutionalization. The minor has a right to consult with counsel throughout the proceedings; to be present at hearings; to have his need for institutionalization decided by "clear and convincing proof"; to confront and cross-examine witnesses; and to offer evidence on his own behalf. The child or his attorney may, however, waive any or all of

[4] The court below emphasized that it was requiring a judicial hearing only "[u]ntil the legislature acts to establish an unbiased tribunal to conduct the probable cause and final hearings." 402 F. Supp. at 1049 n. 18. But it felt "constrained, when legislative bodies have failed to act, to find means of enforcing the constitutional rights being denied. Our action is not intended to pre-empt the state which is free to develop its own safeguards so long as they are fully effective as those which we set out." *Id.* at n. 16.

these rights, except notice and counsel, upon a finding by the court that the waiver by the child is informed and competent, or, if the child is not competent, that the attorney's decision to waive is appropriate. 402 F. Supp. at 1049-1053.

Following the decision of the court below, the defendants appealed the judgment to this Court and made application for a stay pending appeal. A stay was denied by the trial court but subsequently granted by this Court. 96 S.Ct. 558. Probable jurisdiction was noted by this Court on March 22, 1976. 96 S.Ct. 1457.

## SUMMARY OF ARGUMENT

This case requires the Court to decide a novel and difficult question of the "proper resolution of possible competing interests of parents, children and the State." *Wisconsin* v. *Yoder*, 406 U.S. 205, 231 (1972). The issues presented are whether a state may itself, as guardian of minor wards, directly confine them in mental hospitals and institutions for the retarded [5] without court hearings or due process of any kind and whether it may by statute authorize parents or non-public guardians to similarly confine them by unilateral action without due process protections. Resolution of these issues re-

[5] Although children with emotional disturbances are generally treated in mental hospitals and mentally retarded children are placed in schools for the retarded, this Brief will henceforth refer to both types of facilities as "mental institutions." *Amici* wish to note that individuals referred to mental health professionals have traditionally been perceived as suffering from a disease process analagous to a physical ailment. Increasingly, however, many mental health professionals regard these individuals not as sick or ill but rather as displaying behaviors which are indicative of cognitive/emotional problems which are in some way disturbing to others in their environment. Many professionals are accordingly concerned that labels such as "mentally ill" are inappropriate or so inherently vague as to lead to arbitrary classifications with destructive consequences for the individuals concerned.



quire this Court to balance two competing interests to which it has afforded constitutional protection in the past —the right of parents and guardians to control the upbringing of their children and the right of children to due process when their liberty is threatened by state action.

This Court has often been called upon to mediate between the interests of the family on conducting its affairs free from arbitrary state interference and the interests of the state in protecting the welfare of its young citizens. In doing so, it has recognized a presumption in favor of parental prerogatives, stating that "the custody, care and nurture of the child reside first in the parents." *Prince* v. *Massachusetts*, 321 U.S. 158, 166 (1944). But it has also stressed that the state may intervene with parental decisions where those "decisions will jeopardize the health or safety of the child, or have a potential for significant social burdens." *Wisconsin* v. *Yoder*, *supra*, 406 U.S. at 234. In addition, this Court has granted to children of all ages significant procedural due process rights when the state attempts to remove them from their homes and place them in juvenile institutions as a result of alleged delinquent conduct. *In re Gault*, 387 U.S. 1 (1967). This case, however, involves neither a state's efforts to curtail family authority nor its efforts directly to remove children from their homes; rather it involves an attempt by the state either directly to initiate institutionalization of children who are its wards without due process oversight of any kind or indirectly to participate with or authorize parents or other guardians to institutionalize their children, also without due process oversight of any kind.

In deciding this case, this Court should consider the serious and potentially damaging effects of institutionalization upon children. Although institutional treatment may at times be necessary for some children with emo-

tional problems or developmental disabilities, protracted or unnecessary institutional stays produce documented, sometimes irreversible, psychic and developmental harm. Recent studies show that once admitted, many children remain in institutions for months and even years; most are unable to obtain release until their parents, who put them there, are willing to take them home. This problem is exacerbated when the state acts as guardian of a child without natural parents in initiating "voluntary" admissions. Obviously, institutionalization involves major restrictions on a child's liberty. But apart from restrictions upon physical liberty, institutionalization for any substantial period of time causes other equally serious harms to children. As a result of institutionalization, children's natural family and community ties are often severed. Moreover, the impact of institutionalization upon the intellectual and emotional development of children can result in irreversible damage to their future potential as adults. And even if they are released, the mere fact that children have once been institutionalized carries with it a life-long stigma which may cause them to be denied admission to employment, licenses, higher education and access to health benefits.

Given the potential damaging impact of the decision to institutionalize on the child, the Court must also consider the context in which the decision is now made by parents. Parents are generally driven to hospitalization as a result of inability to cope with the problems of the child when they are under conditions of great stress. At the time institutionalization of their children becomes a serious option, parents are often ignorant of or unable to find alternatives by themselves and their own interests or the interests of other family members are likely to be in conflict with what is best for the child. Accordingly, it cannot be assumed that parents will automatically make this decision based solely on what they perceive



to be the child's best interests or that they are sufficiently impartial to judge those interests.

When parents are in such extremity, moreover, the requirement that an examining physician approve the child's admission is not an effective safeguard against unnecessary institutionalization. The physician's decision, as the professional members of the *amici* organizations well know, is heavily influenced by the parents' attitude toward the child and by the physician's inability to command alternative treatment resources for the child. If parents will no longer tolerate their child at home, and the physician cannot find, expedite or order an alternative placement, the physician has no choice but to approve institutionalization of the child. The physician therefore acts as a screening agent for the facility or as the parents' consultant but not as the child's physician of choice. *Cf. Planned Parenthood* v. *Danforth*, —— U.S. ——, 44 U.S.L.W. 5197 (July 1, 1976).

In view of the potentially serious harms to children of institutionalization, *amici* recommend that the Court recognize a constitutional right of all children to procedural due process protections when they are admitted to mental institutions by a state guardian. When the state acts *in loco parentis* to initiate the institutionalization of a mentally handicapped child, concerns of family autonomy are not relevant and prolonged institutionalization is more likely. When parents seek to institutionalize children age twelve and over, a balancing of the rights of the individual adolescent to personal autonomy against the interests of parental autonomy also dictates the due process rights ordered by the court below. As the child matures and approaches adulthood, parents must expect increasingly to share with him decision-making about his future. Thus, where parents and adolescent children disagree on so vital a decision as confinement to a mental

institution, the adolescent should be afforded an impartial forum in which to contest this significant deprivation of liberty.[6] Finally, *amici* believe that younger children below age twelve also deserve the protections of due process when they are threatened with institutionalization for more than the briefest periods of one or two weeks required for inpatient evaluation or respite care. The dangers to younger children from unnecessarily prolonged institutionalization are greater than to older children, and younger children are less able to defend themselves against the traumas of separation from parents and friends. These dangers outweigh the interests of parental autonomy. *Amici* do recognize, however, that there are occasions when conscientious parents must institutionalize children for periods up to two weeks for diagnostic evaluations or, on isolated occasions, place them in appropriate residential facilities for temporary respite from their own obligations. These interludes—if brief and infrequent—do not endanger the child to the same degree that indefinite or prolonged commitments do and they are not inconsistent with a parental intention to keep the child as part of the family. It would seem unnecessary and unreasonably destructive of valid parental autonomy to insist that such brief confinements

[6] Even an older child, of course, may not be competent, for reasons other than age, to make a decision about inpatient treatment or confinement. One should, for example, be particularly sensitive to the possibility that an older mentally retarded child may be functioning at a mental age level below twelve years. The court below required the child's lawyer to report to the court if he deemed the child incompetent to make a decision about requesting a hearing on the need for institutionalization. If the child was found to be incompetent, the lawyer would himself recommend a hearing or waiver and the court would then decide what action to take. 402 F. Supp. at 1053-54 n. 26. *See also Planned Parenthood* v. *Danforth*, *supra*, 44 U.S.L.W. at 5204, recognizing that not all females will be competent to make the abortion decision by themselves.



be surrounded with the same due process protections as longer or indefinite institutional placements.[7]

Accordingly, *amici* support the due process requirements outlined by the court below for institutionalization of children. They do, however, recommend that this Court provide a limited exception for the placement of children under the age of twelve for a one or two week nonrecurring period of evaluation or respite care in facilities appropriate for those purposes, where it is not the intention of the parents to institutionalize their child indefinitely.

Finally, *amici* believe that due process inquiry into the need for any but the briefest institutionalization need not interfere with, and may indeed contribute to, therapeutic objectives for emotionally disturbed and retarded children. Such hearings should help deter unnecessary institutionalization. And they should focus the attention of professionals and parents on locating and creating adequate community based care facilities for handicapped children who need not be institutionalized. The placement of emotionally disturbed and retarded children in normal community settings, whenever possible, but with the specialized help they need, is a fundamental principle of the *amici* organizations.

[7] To insure that this limited exception is not abused, parents might be required to execute an affidavit about the purpose of the admission, the expected duration of confinement (not more than two weeks) and the unavailability of nonresidential or less restrictive services. For example, it should not be acceptable to place a child in a state hospital for respite care in lieu of a group home or community based shelter facility.

## ARGUMENT

### I. THE CONSTITUTION PROHIBITS STATES FROM DIRECTLY OR INDIRECTLY DEPRIVING CHILDREN OF HEALTH, WELFARE OR LIBERTY WITHOUT DUE PROCESS, REGARDLESS OF PARENTAL CONSENT

This Court has previously recognized that involuntary commitment to a mental facility involves a "massive curtailment of liberty," *Humphrey* v. *Cady*, 405 U.S. 504, 509 (1972). Certainly for adults, such a deprivation must be attended by due process procedural safeguards. *See O'Connor* v. *Donaldson*, 422 U.S. 563, 580 (1975) (Burger, C.J., concurring).[8] *In re Ballay*, 482 F.2d 648 (D.C. Cir. 1973).[9] And there can be little doubt that due process safeguards would also apply to any attempt by the state to initiate the involuntary institutionalization of a child. This Court ruled in *In re Gault, supra*, that despite the state's *parens patriae* purpose in juvenile delinquency proceedings, due process required a judicial hearing before children could be removed from their homes and placed in juvenile institutions. Moreover, in a recent case, *Goss* v. *Lopez*, 419 U.S. 565 (1975), the Court ruled that a brief suspension of a few days from public school must be accompanied by rudimentary due process procedures.[10] As Section II of this Brief will

[8] "Commitment must be justified on the basis of a legitimate state interest, and reasons for committing a particular individual must be established in an appropriate proceeding." 422 U.S. at 580.

[9] *See also Lynch* v. *Baxley*, 386 F. Supp. 378 (M.D. Ala. 1974); *Lessard* v. *Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), *remanded on other grounds*, 414 U.S. 473 (1974), *redecided*, 379 F. Supp. 1376 (1974), *remanded on other grounds*, 421 U.S. 957 (1975), *redecided*, —— F. Supp. —— (1976); *Dixon* v. *Attorney General*, 325 F. Supp. 966 (M.D. Pa. 1971); *Bell* v. *Wayne County*, 384 F. Supp. 1085 (E.D. Mich. 1974); *Doremus* v. *Farrell*, 407 F. Supp. 509 (D. Neb. 1975).

[10] Appellants suggest in their Brief at pp. 39-42 that, since commitment to a mental facility is based on the child's need for care and treatment and not on the commission of a specified wrongful act, due process fact-finding procedures are unnecessary. This argument is erroneous. An adult whose commitment is grounded on his status as a sexual psychopath or a mentally disabled person is clearly entitled to a hearing as to whether he meets the statutory criteria for that status. *See Specht* v. *Patterson*, 386 U.S. 605 (1967); *cf. Jackson* v. *Indiana*, 406 U.S. 715 (1972). In addition, a decision that a disturbed or retarded child needs institutionalization is usually based in part on specific behavior attributed to the child, which may be subject to factual dispute.



show, children in mental institutions very often suffer loss of liberty, risks to intellectual and emotional development and stigma similar to children in juvenile facilities. Moreover, children who are institutionalized are often denied education for months and years. Accordingly, where the state is an active participant in the institutionalization of children either through its initiation of admission as their guardian or through its operation of the facility in which they are placed, the reasoning of *Gault* and *Goss* appears to compel due process.

But the proposition that the state may not directly initiate the involuntary institutionalization of a child without affording him procedural safeguards is not dispositive of a major issue in this case.[11] For in the case of the majority of children in the plaintiff class, the state has not itself initiated institutionalization but has instead permitted parents to confine their children without due process safeguards either in public or private institutions.

[11] It is, however, critical to the decision whether the state, acting *in loco parentis* for particular children who have been placed in its custody as a result of parental abandonment or neglect, must provide a hearing before placing such children in mental institutions. *See* Part III A, *infra*, *and cf. Planned Parenthood* v. *Danforth*, *supra*, 44 U.S.L.W. at 5202 ("the State cannot 'delegate to [parents] . . . power which the state itself is absolutely and totally prohibited from exercising. . .'") [citation omitted].

The granting to parents of broad powers of control over their children is customarily in accord with the parents' natural and fundamental rights to supervise the upbringing of their children—rights zealously guarded by this Court against arbitrary state interference on many past occasions. The primary issue in this case, thus, is whether the nature of the decision to commit indefinitely to a mental facility is so threatening to a child's welfare and liberty that the state cannot directly or indirectly, by relying on parental discretion, allow institutionalization without due process protections.[12]

While recognizing that the rights of parents to "establish a home and bring up children" have been deemed "essential," *Meyer* v. *Nebraska*, 262 U.S. 390, 399 (1923), and the "primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition," *Wisconsin* v. *Yoder*, *supra*, 406 U.S. at 232,[13] this Court has nonetheless approved state limitations upon parental decision-making when the child's welfare appeared endangered.

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[12] *Amici* frame their analysis of this case in terms of the appropriate resolution of conflicting interests of parent and child. The court below, however, analyzed the case as one in which children had due process rights to procedural protection from confinement, and the relevant question was whether parents could "waive" such rights for their children. 402 F. Supp. at 1047-1048. *Amici* believe that even if the waiver formulation were used, the conclusions would be similar since setting constitutional procedures to insure a valid waiver of fundamental rights would require the same inquiry into the competence of the child and possible conflicts between parent and child as is necessary to *amici's* analysis.

[13] *Wisconsin* v. *Yoder*, of course, upheld the right of Amish parents to disobey compulsory education laws that required attendance of their children at secular secondary schools and *Meyer* v. *Nebraska* upheld the right of parents to provide foreign language instruction for their children at private schools. *See also Pierce* v. *Society of Sisters*, 268 U.S. 510 (1925) (right of parents to send children to private schools); *Stanley* v. *Illinois*, 405 U.S. 645 (1972) (necessity of providing due process hearing before removal of child from custody of natural father).



> "Acting to guard the general interest in youth's well being, the state as *parens patriae* may restrict the parent's control by requiring school attendance, regulating or prohibiting the child's labor, and in many other ways. . . . The catalogue need not be lengthened. It is sufficient to show what indeed appellant hardly disputes, that the state has a wide range of power for limiting parental freedom and authority in things affecting the child's welfare. . . ." [*Prince* v. *Massachusetts*, *supra*, 321 U.S. at 166-167 (footnotes omitted).]

*See also Ginsberg* v. *New York*, 390 U.S. 629 (1967).

Although the issues are not precisely the same here, *amici* believe that the same balancing of potential harm to the child against harm to the integrity of the family must take place where children's and parental interests are pitted against each other as in cases where the court mediates between asserted state and parental interests.

In its recent decision, *Planned Parenthood* v. *Danforth*, *supra*, this Court had to strike a balance between children's and parents' rights in a situation somewhat analogous to this one. This Court there rejected as unconstitutional a state statute permitting a "parental veto" over minors' abortions within the first twelve weeks of pregnancy.

> ". . . the State may not impose a blanket provision . . . requiring the consent of a parent or person *in loco parentis* as a condition for abortion of an unmarried minor during the first 12 weeks of her pregnancy. Just as with the requirement of consent from the spouse, so here, the State does not have the constitutional authority to give a third party an absolute, and possibly arbitrary, veto over the decision of the physician and his patient to terminate the patient's pregnancy, regardless of the reason for withholding the consent.

> "Constitutional rights do not mature and come into being magically only when one attains the state-defined age of majority. Minors, as well as adults, are protected by the Constitution and possess constitutional rights." [44 U.S.L.W. at 5203-04.]

In *Planned Parenthood* this Court refused to credit the alleged state interest in "the safeguarding of the family unit and of parental authority" as a sufficient justification for requiring parental consent as a condition of the minor's right to abortion.

> "It is difficult . . . to conclude that providing a parent with absolute power to overrule a determination, made by the physician and his minor patient, to terminate the patient's pregnancy will serve to strengthen the family unit. Neither is it likely that such veto power will enhance parental authority or control where the minor and the nonconsenting parent are so fundamentally in conflict and the very existence of the pregnancy already has fractured the family structure. Any independent interest the parent may have in the termination of the minor daughter's pregnancy is no more weighty than the right of privacy of the competent minor mature enough to have become pregnant." [*Id.* at 5204.]

In assessing the relevance of *Planned Parenthood* to the instant case, certain differences are, of course, readily apparent. In *Planned Parenthood*, for example, the parents objecting to an abortion were aligned against the minor and her medical consultant, whereas in this case the parents desiring to institutionalize their child must first obtain the approval of the admitting physician. And while the plaintiffs in *Planned Parenthood* sought and obtained the complete invalidation of the requirement of parental consent, what appellees seek here is only an impartial forum in which minors can contest institutionalization, when they disagree with their parents' recommendation. *Cf. Planned Parenthood, supra,*



44 U.S.L.W. at 5208-5209 (Stewart and Powell, J.J., concurring).[14] If, after full consideration of the child's problems and needs at a due process hearing, the impartial tribunal decides that institutionalization is appropriate, it can still order such institutionalization over the child's objections.

But, despite these differences, a careful reading of *Planned Parenthood* suggests that the competing interests in both cases are similar and that the results should also be similar. Both cases involve the issue whether minors, as well as adults, have constitutionally protected rights to liberty and self autonomy, and both cases involve the question whether the state has the constitutional authority to give a third party the power to take away such rights from a minor even though it could not itself do so directly.

The presumption in favor of parental control of minor children is strong. But, as *Planned Parenthood* indicates, parents cannot be affirmatively authorized by the state to act in serious derogation of the rights of their children to life and liberty without any semblance of due process protections for the child.

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[14] "The Court's opinion today in *Bellotti* v. *Baird*, —— U.S. ——, ——, suggests that a materially different constitutional issue would be presented under a provision requiring parental consent or consultation in most cases but providing for prompt (i) judicial resolution of any disagreement between the parent and the minor, or (ii) judicial determination that the minor is mature enough to give an informed consent without parental concurrence or that abortion in any event is in the minor's best interest. Such a provision would not impose parental approval as an absolute condition upon the minor's right but would assure in most instances consultation between the parent and child."

In *Bellotti* v. *Baird*, —— U.S. ——, 44 U.S.L.W. 5221 (U.S. July 1, 1976), the Court vacated and remanded to allow for state court interpretation of a law which required parental consent for a minor's abortion, but permitted a judge to grant consent for good cause, if the parents refused.

## II. THE DECISION TO INSTITUTIONALIZE SERIOUSLY ENDANGERS A CHILD'S HEALTH, WELFARE AND LIBERTY

Although in some cases, hospitalization of an emotionally disturbed or developmentally disabled child may be appropriate and indeed beneficial to the child, there is nonetheless a serious risk of grave and often irreversible harm to a growing child stemming from institutionalization for any significant period of time. This potential for harm to the child is coupled with the unfortunate circumstance that parents are often driven to institutionalization by conflicting motives, and by ignorance of how to obtain community based help or by the unavailability of alternatives. The result has traditionally been to overinstitutionalize children with emotional or developmental problems with resultant grave harms to these children.

### A. The Decision to Institutionalize a Child Interferes with the Child's Liberty and Development, and Presents a Substantial Likelihood of Serious, Irreversible Harm

Institutionalization, by its very nature, has a severe impact on a child's liberty. The child is taken from his family, and is subjected to the rigid structure and rules of a closed facility, including locked wards, isolation cells, physical and chemical restraints and restriction of contact with the extrahospital community.[15] Of course, the

[15] *See, e.g., Price* v. *Sheppard*, No. 320 (Minn. Feb. 20, 1976) (use of electroconvulsive therapy on minors); *Hearings on the Use of Children as Subjects in Biomedical and Behavioral Research before the National Commission for the Protection of Human Subjects in Biomedical and Behavioral Research* (April 9, 1976) [hereinafter Hearings] (Testimony of Dr. Robert Sprague) (66% of children in institution for retarded are on psychotropic drugs without sufficient monitoring or individualization of dosage); Mitchell, *Experimentation On Minors: Whatever Happened To Prince* v. *Massachusetts?*, 13 Duquesne L.Rev. 919 (1975) (medical experimentation performed on minors in mental institutions).



degree of liberty children enjoy differs from adults', since they are subject in varying degrees to the control of their parents. But there is little question that a child's liberty of movement and how he spends his time is substantially restricted when he moves from home and neighborhood into a mental facility. The change in his situation is often not qualitatively different from that of the delinquent child placed in a rehabilitative facility by the juvenile court, a move which this Court has already circumscribed with due process procedures.[16]

But apart from restrictions of physical liberty, institutionalization for any substantial period of time can cause other equally serious harms to children; its impact on their intellectual and emotional development can result in irreversible damage to their future potential as adults, and the mere fact of institutionalization carries with it a lifelong stigma which may prejudice them in admission to employment, licenses, higher education and access to health benefits.

#### 1. *Institutionalization Can Result in Loss of Family and Community Ties*

When a child is institutionalized for any period of time,

> "His world becomes 'a building with white-washed wall, regimented routine and institutional hours . . .' Instead of mother and father and sisters and brothers and friends and classmates, his world is peopled by guards, custodians, [and] state employees . . . ."

[16] *See Heryford* v. *Parker*, 396 F.2d 393, 396 (10th Cir. 1968), "It is the likelihood of involuntary incarceration—whether for punishment as an adult for a crime, rehabilitation as a juvenile for delinquency, or treatment and training as a feeble-minded or mental incompetent—which commands observance of the constitutional safeguards of due process."

*In re Gault, supra,* at 27, *quoting Holmes' Appeal,* 379 Pa. 599, 616, 109 A.2d 523, 530 (1954). Deprivation of family and community life, however brief or necessary, is almost certainly traumatic for both younger children and adolescents.[17] Although brief residential stays in mental facilities may on occasion be necessary for evaluation or treatment of disturbed children or for the specialized training or respite care of retarded children, it is still a serious matter for the child.[18]

Lengthy institutionalization, however, compounds the trauma by weakening family ties. It often amounts to and in fact does lead to formal severance of parental involvement. After he has been away from home for a substantial period, the child's "parents have sort of fallen out of love with him" and reintegration into the realigned family circle becomes more difficult.[19] In many cases, admission to a mental institution amounts to a life sentence. According to the Joint Commission on the Mental Health

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[17] *See, e.g.,* M. Grob & J. Singer, Adolescent Patients in Transition 115 (1974) [hereinafter Grob & Singer]. A survey of adolescents who had been institutionalized in a private facility of high quality showed that a majority of their families "had a negative view" of the hospitalization. They cited as "added problems which accrued from hospitalization . . . exposure to other sick people, drugs, sex, removal from the community of normal adolescents" and the fact that "the child had irretrievably lost an entire stage of his development." *Id.* at 120, 116.

[18] The younger the child, the shorter the period before he suffers the psychological pangs of abandonment. J. Goldstein, A. Freud & A. Solnit, Beyond the Best Interests of the Child, 40-49 (1973).

[19] DeMyer, *New Approaches to the Treatment of Very Young Schizophrenic Children,* in The Mental Health of the Child, 424 (Public Health Service Publication No. 2168, 1971). *See* Hammond, *Parental Interest in Institutionalized Children: A Survey,* 20 Hosp. & Comm. Psychiatry 338 (1969) (a survey of 5400 parents of Willowbrook residents to determine if they wanted progress reports or exploration of the feasibility of outplacement for their retarded children produced only 15% replies; only 10% of those replying wanted progress reports, and fewer than 2% were willing to discuss the child's return home).



of Children, one fourth of the children admitted to one state's mental hospitals "can anticipate being permanently hospitalized for the next 50 years of their lives." [20] Mentally retarded institutional residents, 90 percent of whom are initially admitted as minors, have a current median stay of 15 years.[21] In general, children are more likely to stay longer in institutions than adults, because their ability to leave is often blocked by family unwillingness to take them back.[22]

Testimony before the trial court in this case emphasized that mental hospitalization means isolation from family, school and community, the loss of a "social support system" for the child, a "derailment from the usual course of one's life" and it signals difficulties in reentering family, school and neighborhood upon release. Testimony of Dr. Messinger (620-621a).[23]

Thus, there is a definite threat to an institutionalized child after a certain point of time [24] of losing his place in the family and community.

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[20] Joint Commission on the Mental Health of Children, Crisis in Child Mental Health: Challenge for the 1970's at 6 (1969) [hereinafter Joint Commission Report].

[21] Cohen, *Advocacy,* in President's Committee on Mental Retardation, The Mentally Retarded Citizen and the Law 592, 599 (1976).

[22] Joint Commission Report, *supra,* at 271. *See also,* Reiger, *Changing Concepts in Treating Children in a State Mental Hospital,* 1 Int. J. Child Psychotherapy 89, 104 (1972) ("most mentally ill children who are treated in a state hospital overstay, by months and even years, the optimum period required for their partial or total social restoration"). In New York State hospital inpatients stay significantly longer than any other age group except those over 64. Weinstein, *et al., Relationship Between Lengths of Stay In and Out of New York State Hospitals,* 130 Am. J. Psychiatry 904, 907 (1973).

[23] References to material in the Appendix will appear as (Xa).

[24] *See J. L.* v. *Parham,* —— F. Supp. ——, No. 75-163 M.A.C. (M.D. Ga. 1976), *stay granted,* 96 S.Ct. 1503 (1976).

> ". . . the evidence indicates there are some parents who . . . under the guise of admitting a child to a mental hospital actually abandon their child to the state." (sl. op. at 39-40.)

The child's interest in remaining in the mainstream of family and community life is at least as compelling as the parent's interest in retaining control of his child. In *Stanley* v. *Illinois*, *supra*, 405 U.S. at 653, this Court underscored the parent's interest in not being "needlessly separate[d] . . . from his family." Removal of a child from his family, friends and community is just as much a severe deprivation. Thus, in *Wisconsin* v. *Yoder*, *supra*, 406 U.S. at 211-212, the Court recognized that a secular secondary education "takes [children] away from their community, physically and emotionally, during the crucial and formative adolescent period of life" and thereby may "result in great psychological harm to Amish children."

Children thus deserve due process protections when they are institutionalized initially, and frequent periodic review thereafter to safeguard their interest in remaining in the family and in the community.[25]

### 2. *Institutionalization Threatens the Intellectual and Emotional Development of Children*

It is widely recognized that although brief periods of residential treatment may occasionally be necessary for disturbed or retarded children, any unnecessary prolongation of institutional treatment presents the threat of deleterious long-term effects on cognitive, emotional and social development.[26]

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[25] *See* Joint Commission Report, *supra*, at 44.

[26] For these reasons many professional child care workers have a "pervasive feeling" that institutionalization should be a last resort. R. Glasscote, *et al.*, Children and Mental Health Centers 20 (1972); Joint Commission Report, *supra*, at 269.

> "It is the conviction of this Commission that no child or young person should be placed in a mental hospital without a careful professional diagnosis and without preliminary attempts to help him through other forms of treatment on an outpatient basis in his own home or at least in his home community."

The expert testimony before the trial court also emphasized that hospitalization for disturbed children and adolescents should be a "last resort." Psychiatrists stressed that the potential damaging effect of institutionalization even for a "couple of months" was "tremendous." Testimony of Dr. Feiner (474-475a); Dr. Kandler (582a); Dr. Ingall (590a); Dr. Messinger (620-622a, 631a, 633-634a).



To develop normally, a child must undergo certain basic life experiences at particular stages of his development. For very young children, there is an overwhelming need for a consistent, affectionate "mothering" relationship with one person. Without adequate "mothering," the child never learns to form close personal relationships or to develop inner self controls. As the child grows, he needs individualized responses and guidance in his attempts to master physical, social and intellectual skills. If he is not responded to promptly and positively, he will not continue to strive for mastery of these skills and he may suffer emotional disturbance.[27] A growing child also needs a "wide range of experiences in seeing, hearing, touching, handling and moving" or he will not learn to talk, to develop his intellectual skills or to master conceptualization and abstraction.[28] Further, the preadolescent child needs an increasing involvement with the community, outside of his immediate family environment, if he is to learn to function as a constructive member of society.[29]

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[27] J. Bowlby, Child Care and the Growth of Love 60-61 (1953) [hereinafter Bowlby].

[28] Joint Commission Report, *supra*, at 321.

[29] Joint Commission Report, *supra*, at 331. The literature indicates that retarded children have an intensified need for all these life experiences. Their more limited cognitive skills make parental contacts and community ties even more necessary if the child is to gain a measure of self-autonomy and become as self-sustaining an adult as he can. *See generally* W. Wolfensberger, Normali-

In view of these developmental needs, it is significant that studies of young children in institutions document the conclusion that "most infants living in institutions do not get enough mothering in purely quantitative terms." Infant care is typically routinized, the baby "is fed, diapered, lifted up and put to sleep on a schedule, that is almost exclusively externally determined." The mother-child communications that form the infant's earliest and often most decisive learning experiences are "reduced to a minimum." [30]

In most institutions there are several different "shifts" of staff each day and the rate of staff turnover is extremely high. In one facility studied, the children on one ward were cared for by 246 different adults in a three and one-half year period.[31] Under these circumstances consistent "mothering" is an impossibility.

The growing child in institutions suffers deprivation as well. He seldom, if ever, receives the individualized response he needs for his experimental forays into physical and mental skill development.

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zation (1972); W. Wolfensberger & L. Glenn, Program Analysis of Service Systems (1973).

> "The principle of normalization is deceptively simple . . . [T]he means employed for training should be as culturally normative as possible. . . . If the ultimate goal is the individual's optimal level of self-sufficiency, then the program processes and content that are used should be as close as possible to those typically utilized in the normal culture. Only in this way will retarded citizens develop more normal adult behavior and improve their relations with others."

Glenn, *The Least Restrictive Alternative in Residential Care and the Principle of Normalization*, in The Mentally Retarded Citizen and the Law, *supra*, at 501 [hereinafter Glenn].

[30] S. Provence & R. Lipton, Infants in Institutions 19 (1962) [hereinafter Provence & Lipton].

[31] N. Hobbs, The Futures of Children 129 (1975) [hereinafter Hobbs].



> "The most serious deficiency of the total (institutional) program is the lack of awareness that each child is an individual. . . . The children are herded in groups from one place to another and no opportunity arises for them to be treated as individuals. Individual treatment is, of course, essential for a child to grow into a socially sensitive person." [32]

As one research team observed, "any attempt to make a personal decision such as is typical of normal childhood will probably cause the individual to be punished because he is deviating from administrative routine." [33]

Children in institutions are also unlikely to be exposed to the stimuli and challenges a growing child needs. They are often confined to one indoor living unit and one daily period of outdoor recreation. "Nothing is new, nothing is different, therefore nothing is memorable. Life is dull and plodding; an interminable sequence of sameness over and over again." [34]

Finally, life in an institution rarely offers opportunity for integration of a child into community life. The family is the usual "socializing agent" and bridge to community life. Children of a very young age develop marked identification with their kinfolk which assists them in finding a community identity.[35] When they are denied community

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[32] B. Flint, The Child and the Institution 16 (1966).

[33] H. Leland & D. Smith, Mental Retardation: Present and Future Perspectives 84 (1974) [hereinafter Leland & Smith]; Bowlby, *supra*, at 61:

> "The child is not encouraged to individual activity because it is a nuisance; it is easier if he stays put and does what he is told . . . often the children sit inert or rock themselves for hours together. . . . In these conditions, the child has no opportunity of learning and practising functions which are as basic to living as walking and talking."

[34] B. Flint, *supra*, at 15.

[35] Elkin, *Agents of Socialization*, in Children's Behavior 360 (Bergman ed. 1968).

experiences and involvement, "their behavior as young adults reflects their lack of contact with normal people during their developmental period." Institutionalized children "have as models only other handicapped persons." [36]

There has been extensive empirical documentation of the psychological and developmental harms that beset an institutionalized child or adolescent. These include low scores on intelligence tests, poor progress in school, deficiencies in emotional and social development. These harms accelerate with the length of the institutionalization, the age at which the child was first admitted and the impoverished conditions in the institution.[37] Institutionalized infants show marked retardation in intellectual and language development.[38] Moreover, this retardation does not readily disappear even when the infants are placed in foster homes before the age of two.[39] This phenomenon applies to well-staffed nurseries, as well as to poorly run state hospitals. "[T]he residential nursery considered as a language laboratory appears to be inferior to a 'good' working-class home." [40]

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[36] Leland & Smith, *supra*, at 86; Glenn, *supra*, at 499.

[37] Hobbs, *supra* at 135, 142-143. Of course, in recent years, mental health and mental retardation professionals have learned more about how, given adequate resources, institutions can have more effective habilitation programs. Possibly, in the relatively few institutions which now have such adequate habilitation programs, children would not show such impaired development relative to children who are not institutionalized. Unfortunately, such comparative information is not currently available.

[38] Yarrow, *Maternal Deprivation: Toward an Empirical and Conceptual Reevaluation in Maternal Deprivation* 3, 9-11 (Child Welfare League of America, 1962) [hereinafter Yarrow].

[39] Provence & Lipton, *supra*, at 149, 155-156.

[40] Tizard & Joseph, *Cognitive Development of Young Children in Residential Care: A Study of Children Aged Twenty-Four Months*, 11 J. Child Psychology-Psychiatry 177, 185 (1970). *See also* Lagmeir & Matejcek, *Mental Development of Children in Families and in Infant Homes*, 4 Soc. Sci. & Med. 569, 570-573 (1970).



The harms of institutionalization extend to social and emotional as well as cognitive development. Institutionalized children tend to become "apathetic" [41] and unable to form meaningful relationships with others, or they acquire "affection hunger" characterized by "incessant and insatiable seeking of affection." [42] This emotional and social lag, like its cognitive counterpart, typically persists even after the institutionalized infant is removed to a family environment.[43]

In the case of mentally retarded children, the harms of institutionalization are even more dramatic, particularly with younger children. Several comparisons of matched institutionalized and noninstitutionalized children with Down's Syndrome (mongolism) have shown that the home-reared children scored consistently higher in IQ tests.[44] Similar findings have been made as to comparative verbal functioning between noninstitutionalized and

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[41] *See* Hobbs, *supra*, at 143.

[42] Yarrow, *supra*, at 14.

[43] Provence & Lipton, *supra*, at 150-155. *See also* Youngleson, *The Need to Affiliate and Self-Esteem in Institutionalized Children*, 26 J. Personality and Soc. Psychology 280 (1973); Tizard & Rees, *The Effect of Early Institutional Rearing on the Behavior Problems and Affectional Relationships of Four-Year-Old Children*, 16 J. Child Psychology-Psychiatry 61 (1975).

[44] Stimpson, *et al.*, *Effects of Early Institutionalization on Growth and Development of Young Children with Down's Syndrome*, 67 Mich. Med. 1213 (1968); Centerwell & Centerwell, *A Study of Children with Mongolism Reared in the Home*, 25 Pediatrics 678 (1961). A third study compared matched groups of institutionalized and noninstitutionalized mentally retarded children in their ability to form learning sets, *i.e.*, to learn from experience; "All community subjects demonstrated significant amounts of learning . . . whereas one-third of the institutional group continued to function at chance level." The younger institutionalized children in this study exhibited the poorest performances of all. Kaufman, *The Formation of a Learning Set in Institutionalized and Non-Institutionalized Mental Defectives*, 67 Am. J. Men. Def. 601, 604 (1963).

institutionalized retarded children.[45] And some studies also suggest that the motor development of institutionalized retarded children is inhibited by lack of stimulation, enforced quiescence and verbal chastisement following active or experimental behavior.[46]

It is for these reasons that professionals in the mental illness and retardation fields caution against the institutionalization of a child[47] except when it is absolutely necessary.

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[45] ". . . the difference in verbal ability between the two groups was attributable to the institutional environment itself . . . even those children who could speak on entry into the institution were found to be significantly retarded in present verbal functioning when compared with a matched group of day school [retarded children]."

Lyle, *The Effect of an Institution Environment Upon the Verbal Development of Imbecile Children*, 1 J. Men. Def. Res. 1, 12 (1960). When the institutionalized youngsters were removed into a residential family unit, they "developed verbally at a greater rate than the matched controls which remained in the institution." *Id.* at 21. Younger retarded children appear to suffer the greatest developmental harms. Sternlight & Siegel, *Institutional Residence and Intellectual Functioning*, 12 J. Men. Def. Res. 119, 123 (1968).

[46] Klaber & Butterfield, *Stereotyped Rocking—A Measure of Institution and Ward Effectiveness*, 73 Am. J. Men. Def. 13, 18-19 (1968) [hereinafter Klaber & Butterfield]; Kaufman, *The Effects of Institutionalization on Development of Stereotyped and Social Behaviors in Mental Defectives*, 71 Am. J. Men. Def. 581 (1967); Mosley, *et al.*, *Effects of Social and Non-Social Stimuli on the Stereotyped Behaviors of Retarded Children*, 74 Am. J. Men. Def. 809 (1970).

[47] "[N]o matter how good a treatment program for children in the state hospital is, hospitalization of an emotionally disturbed child is not the best answer."

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The "basic experiences which a child needs in order to grow into an emotionally happy, healthy and productive adult . . . cannot be found in a hospital."

Reiger, *Changing Concepts in Treating Children in State Mental Hospitals*, 1 Int. J. Child Psychotherapy 89, 104, 107 (1972).

[Footnote continued on page 31]



The inherent dangers of institutionalization are, moreover, exacerbated for many children because they are placed in substandard facilities, lacking in adequate staff, physical facilities and constructive programs designed to improve or cure the child's underlying condition. In 1969 the Joint Commission reported that each year thousands of minors are removed from their homes, schools and communities and confined to hospital wards with psychotic adults or to depersonalized institutions which deliver little more than custodial care.[48] The report cited shortages of professional staff, untrained attendants, failure to provide education and recreation, "outmoded facilities" operating on "long abandoned theory," and it concluded pessimistically that "instead of being helped, the vast majority [of children] are the

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[47] [Continued]

"It makes little difference whether the institution is called hospital or school, whether it is supposedly medically oriented or educationally oriented; in either case the child is trained to live in an institutional setting, and thus learns many of the very things that we do not want him to learn."

Leland & Smith, *supra*, at 87.

[48] Joint Commission Report, *supra*, at 269.

"What happens to these emotionally sick children for whom there are no services in the community? Each year, increasing numbers of them are expelled from the community and confined in large state hospitals so understaffed that they have few, if any professionals trained in child psychiatry and related disciplines. It is not unusual in this year 1969 to tour one of these massive warehouses for the mentally ill and come upon a child, aged nine or ten, confined on a ward with 80 or 90 sick adults." *Id.* at 5.

*Cf. Jackson* v. *Indiana*, 406 U.S. 715, 734-735 n. 17 (1972): "[There are] substantial doubts about whether the rationale for pretrial commitment—that care and treatment will aid the accused in attaining competency—is empirically valid given the state of most of our mental institutions." *See also* A. Stone, Mental Health and Law: A System in Transition 21 (1975) ("As one considers the entire law-mental health system, its most tragic faults are to be found in what it does to the young.").

worse for the experience." Joint Commission Report, *supra*, at 6.

There are, of course, some high-quality public and private residential facilities for mentally ill and retarded children.[49] But unfortunately, good residential treatment is very expensive and therefore, unless publicly supported, inaccessible to the vast majority of parents.[50] The state mental hospitals to which most children are admitted are chronically underfinanced and overcrowded. Most institutions for the mentally retarded are in an equally deplorable state. As the National Association for Retarded Citizens reports:

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[49] Most minors who are hospitalized for mental illness or institutionalized for retardation go to public facilities. In 1966, there were 8,400 children in private mental hospitals compared to 27,400 in state and county mental hospitals, 8,000 in residential treatment centers and 28,000 in general hospitals with psychiatric services. Joint Commission Report, *supra*, at 268. In 1973 there were 25,830 admissions under eighteen to state and county mental hospitals. HEW, Pub. No. (ADM) (75-158), Statistical Note 115, at Table 1 (1975) [hereinafter Statistical Note 115].

In 1974, 42% of the residents of public residential facilities for the mentally retarded (approx. 60,000) were of school age (3-21). Approximately 30% of these children were only "moderately" retarded. Of new admissions to such facilities during 1974, 67.5% were age 3-21 and 3% under age two; 25.6% of all new admissions consisted of moderate, mild and borderline retarded persons of school age. Only 11% of the facilities believed that they had adequate staffing and their median population was 585. Nat. Assoc. Supts. of Public Residential Facilities, Current Trends and Status of Public Residential Services for the Mentally Retarded 7, 17-18, 45 (1975) [hereinafter Current Trends].

[50] It requires "an all-embracing therapeutic environment . . . individualized, highly skilled attention to . . . educational and recreational requirements . . . highly trained mental health specialists . . . counselling services . . . available to . . . parents." Joint Commission Report, *supra*, at 271. *See also* American Psychiatric Association, Standards for Psychiatric Facilities Serving Children and Adolescents (1971).



> "Most residential facilities for the retarded throughout the country are large, overcrowded, and impersonal. . . . Too often seclusion and restraint are used for the convenience of the staff or as a means of punishing the residents. . . . Abuse, neglect, accidents and questionable deaths are not adequately investigated or reported." [51]

In *New York State Association for Retarded Children* v. *Rockefeller*, 357 F. Supp. 752, 756 (E.D. N.Y. 1973), the judge labelled conditions at the Willowbrook State School for the Mentally Retarded "inhumane," citing "failure to protect the physical safety of . . . children, and deterioration rather than improvement after they were placed in Willowbrook School." In *Wyatt* v. *Stickney*, 344 F. Supp. 387, 391 (M.D. Ala. 1972), *aff'd sub nom Wyatt* v. *Aderholt*, 503 F.2d 1305 (5th Cir. 1974), the court announced: "Put simply, conditions at Partlow are grossly substandard"; it is "a warehousing institution which, because of its atmosphere of psychological and physical deprivation, is wholly incapable of furnishing [habilitation] to the mentally retarded and is conducive only to the deterioration and the debilitation of the residents."

Children placed in such substandard institutions tragically receive little or nothing in return for the deprivations of liberty and developmental harms they suffer.

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[51] NARC, Policy Statements on Residential Care 6, 9 (1968). *See also* Leland & Smith, *supra*, at 81 ("Virtually all of the large general residential institutions today are warehouses for children"); R. Kugel & W. Wolfensberger, Changing Patterns in Residential Services for the Mentally Retarded 438-439 (1969) ("the vast majority [of attendants] come to the job with no relevant past experience . . . no particular educational qualifications . . . fewer than two percent of all institutional personnel are classified as psychiatrists, psychologists and social workers . . . hardly any physicians are boarded [board certified] in their specialties").

### 3. *Institutionalization Stigmatizes a Child Thereby Causing Him Future Harm*

Confinement in a mental facility carries a special stigma, not present in placements of children in general hospitals, camps or boarding schools. *See* Testimony of Dr. Ingall (596a); Dr. Messinger (622a); *In re Ballay*, 482 F.2d 648, 668 (D.C. Cir. 1973);[52] *Matthews* v. *Hardy*, 420 F.2d 607, 610-611 (D.C. Cir. 1969), *cert. denied*, 397 U.S. 1010 (1970).

Institutionalization in such a facility may produce a negative self-image in the child.[53] It also produces negative expectations in those with whom he later comes into contact, including teachers and prospective employers.[54] There is also evidence suggesting that persons with mental disturbances suffer greater rejection from their peers if they seek help in an inpatient psychiatric residence, rather than from a clergyman or a physician or on a psychiatric outpatient basis.[55] Finally, and perhaps most critically, former mental patients suffer documented discrimination in job placement, admission into higher

[52] *See also* Joint Commission Report, *supra*, at 269.

[53] One study which interviewed 110 mildly retarded former institutional residents found:

> "All persons interviewed said that their former status had burdened them with a shattering stigma and that they were forced to create elaborate ways of evading recurrent social ostracism—for instance, by rejecting as false the initial diagnosis and inventing ingenious ways to cover real deficiencies."

I Issues in the Classification of Children 214 (N. Hobbs ed. 1975).

[54] *See* Whatley, *Social Attitudes Toward Discharged Mental Patients*, in The Mental Patient: Studies in the Sociology of Deviance 401 (1968). Because of a "lingering social stigma attached to newly discharged patients . . . their social relations are often characterized by social distance, distrust or denial of employment." *See also* Grob & Singer, *supra*, at 117.

[55] Phillips, *Rejection: A Possible Consequence of Seeking Help for Mental Disorders*, in Mental Illness and Social Processes 63 (T. Scheff ed. 1967).



education,[56] military and government services and applications for licenses and health insurance.[57]

> ". . . a former mental patient may suffer from the social opprobrium which attaches to treatment for mental illness and which may have more severe consequences than do the formally imposed disabilities. Many people have an 'irrational fear of the mentally ill.' The former mental patient is likely to be treated with distrust and even loathing; he may be socially

[56] This Court has already acknowledged that short-term suspensions of children from school "could seriously damage the students' standing with their fellow pupils and their teachers as well as interfere with later opportunities for higher education and employment." *Goss* v. *Lopez*, *supra*, 419 U.S. at 575 (1975). *See also*, *In re Gault*, *supra*, 387 U.S. at 23-24 (1967). Former Secretary of the Department of Health, Education and Welfare, Elliot Richardson, has declared that "the inappropriate labelling of children as *delinquent, retarded, hyperkinetic, mentally ill, emotionally disturbed* . . . has serious consequences for the child." Hobbs, *supra*, Preface at ix.

[57] *See* Testimony of Dr. Feiner (475a); Dr. Messinger (622a); American Psychiatric Association, Task Force Report 9, Confidentiality and Third Parties 27, 53-59 (1975) ("Attitudes of a large part of our social world are still prejudicial and the livelihood and social well-being of some of our patients can be threatened in reality by . . . disclosures"; rejection by school systems and many government agencies of those with psychiatric histories; use of psychiatric information in school records to detriment of child). N. Spingarn, Confidentiality, A Report of the 1974 Conference of Confidentiality of Health Records 5 (American Psychiatric Association 1975) (graduate school rejection on basis of a student's history of emotional problems). *See also* The Mentally Retarded Citizen and the Law, *supra*, chs. 6, 8, 10, 11.

There is also evidence that once hospitalized, a mental patient is more likely in the future to be differentially diagnosed as in need of rehospitalization.

> "Physicians responsible for hospitalization seem, unwittingly, to take this history into account, independent of the number of symptoms and apparently even the severity of the patient's present illness."

Roth, *Some Comments on Labelling*, Bulletin of the American Academy of Psychiatry and the Law (in press, 1976) *citing* Mendel & Rapport, *Determinants of the Decision for Psychiatric Hospitalization*, 20 Arch. Gen. Psychiatry 321 (1969).

ostracized and victimized by employment and educational discrimination." [58]

### B. The Decision to Institutionalize a Child Is Often Made on the Basis of Conflicts of Interest Between the Child and Other Family Members or Because of Ignorance or the Unavailability of Alternative Resources

The consequences of institutionalization for children require that the initial decision be made in a manner which provides assurances that the child's interests in remaining in the mainstream of family and community life and avoiding developmental harms is protected. Institutionalization for mental illness or retardation is not, as appellants argue, Brief for Appellants at 40, primarily a medical decision in which parents' interests can be assumed to be in harmony with their children's interests. *Cf. Planned Parenthood, supra.*[59] Rather, it is too often a decision based on whether the child's family has sufficient resources, emotional and financial, to tolerate the child's behavior at home and whether the community has sufficient tolerance for his behavior or resources to offer the family an alternative to institutionalization.[60]

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[58] Note, *Developments in the Law, Civil Commitment of the Mentally Ill*, 87 Harv.L.Rev. 1190, 1200 (1974) (footnotes omitted).

[59] *Cf. Planned Parenthood, supra*, 44 U.S.L.W. at 5212-5213 (Stevens, J. concurring in part & dissenting in part). Justice Stevens referred to the fact that "the most significant consequences of the decision [to abort] are not medical in character . . . . In each individual case factors much more profound than a mere medical judgment may weigh heavily in the scales. The overriding consideration is that the right to make the choice be exercised as wisely as possible."

[60] *See, e.g.*, Lindsey, *Adolescent Pathways to Residential Treatment: The Enforced Expedition*, 9 Adolescence 135 (1974). This survey suggests that "rather than performing an illness-reduction service, mental hospitals alleviate community and family displeasures through an annoyance-reduction service." *Id.* at 136. The study showed that most adolescent admissions into a public mental hospital resulted from "unmanageable" or "inappropriate" behavior as defined by police, community members or family. *Id.* at 140. The author concluded: "[F]or most of these adolescents the prescription of residential placement is more often the result of a response on the part of social agencies in the adolescent's social world than by the specific nature of the behaviors performed by the adolescent." *Id.* at 143. He warned "mental illness is distinctly different from physical illness. Mental illness is not just an adolescent's private troubles and personal problem. Rather, it is a label applied to the alleged and inappropriate behavior engaged in by the adolescent. The conflictive nature of this behavior emerges from an analysis of the social environment of the prepatient adolescent." *Id.* at 144.



This is not to say that the parents should not have an active voice in the ultimate decision. Their counsel, experiences and problems in coping with the child should be given careful attention. *Cf. Planned Parenthood* v. *Danforth, supra*, 44 U.S.L.W. at 5210 (Burger, C.J., White & Rehnquist, J.J., concurring & dissenting).

> "The abortion decision is unquestionably important and has irrevocable consequences whichever way it is made. Missouri is entitled to protect the minor unmarried woman from making the decision in a way which is not in her own best interests, and it seeks to achieve this goal by requiring parental consultation and consent. This is the traditional way by which States have sought to protect children from their own immature and improvident decisions."

*See also id.* at 5209 (Stewart & Powell, J.J., concurring).

> "There can be little doubt that the State furthers a constitutionally permissible end by encouraging an unmarried pregnant minor to seek the help and advice of her parents in making the very important decision whether or not to bear a child. That is a grave decision, and a girl of tender years, under emotional stress, may be ill-equipped to make it without mature advice and emotional support."

Finally, Justice Stevens, dissenting in *Planned Parenthood*, stresses "the State's interest in maximizing the probability that the decision be made correctly and with full understanding of the consequences of either alternative."

> "It is unrealistic, in my judgment, to assume that every parent-child relationship is either (a) so perfect that communication and accord will take place routinely or (b) so imperfect that the absence of communication reflects the child's correct prediction that the parent will exercise his or her veto arbitrarily to further a selfish interest rather than the child's interest." *Id.* at 5212-5213.

### 1. *Parents Often Have Conflicting Interests When They Decide to Institutionalize Children*

Testimony in the court below emphasized that a mentally ill child's problems are "inextricably connected" with his relationships with parents and other family members. As Dr. Messinger explained at trial:

> ". . . . it is impossible to understand the symptoms and behavior of any one member of the family without understanding their role in the family in meeting family equilibrium." (617a)

Some children unwittingly become the "scapegoats" for family hostilities; some parents have "hidden agendas" and even unconscious motivations for institutionalizing the child. A parent may be mentally ill or under severe psychological stress himself, and projecting his own illness onto the child. Testimony of Dr. Feiner (470-472a); Dr. Ingall (588-589a, 601a); Dr. Messinger (617-619a, 621a, 628a).[61]

The Joint Commission Report, *supra*, at 263, accurately acknowledged "a growing recognition that a child's emotional disturbance is frequently . . . associated with the complex and intricate interpersonal relations within the family and the interactions that the family has with larger social systems." Indeed, the hospitalization of named plaintiffs in this case, according to the court below, had been triggered by factors so diverse as inability of a child to get along with one of his divorced parents, family fatigue, fear of a mother's nervous breakdown, a father's poor health, a foundering marriage,

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[61] *See also* Lidz, *Parental Behavior and the Origins of Schizophrenia* (marital schisms or skewered relationships in all families of schizophrenic children studied) and Teicher, *Why Adolescents Kill Themselves* (profile of suicidal adolescents displays long-standing problems with family, escalating into alienation) in Mental Health of the Child 267, 329 (NIMH, 1971).



intractable physical ailments and delinquent behavior. 402 F. Supp. at 1043-1044.

The motives of parents in deciding on institutionalization for a mentally ill child are not necessarily blameworthy; they may simply reflect priorities for family survival.[62] One commentator has listed such motives as including the interests of other children in the family, the mental and physical frustration of the parents, economic strain resulting from the care of the child, the stigma of the handicap itself, hostility toward the child caused by fatigue and frustration of the parents' success-oriented expectations for the child.[63] But, as the court below and several other courts have recognized, these interests compete with those of the institutionalized child. *See, e.g., Heryford* v. *Parker, supra*, 393 F.2d at 396; *Saville* v. *Treadway*, 404 F. Supp. 430, 432 (M.D. Tenn. 1974); *In re Long*, 25 N.C. App. 702, 214 S.E.2d 626, 629 (1975); *J.L.* v. *Parham*, —— F. Supp. —— No. 75-163 M.A.C. (M.D. Ga. 1976), *stay granted*, 96 S.Ct. 1503.

### 2. *Parents Often Decide to Institutionalize Children Because Alternative Care in the Community Is Unknown or Unavailable to Them*

Parents of emotionally disturbed or retarded children are often driven to institutionalization because they cannot locate or obtain community based care for their children,[64] or because such care does not exist.

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[62] Grob and Singer, *supra*, at 122 (followup interview of institutionalized minors and their families showed that virtually no parents perceived the hospitalization as resulting in cure of the child's problems. "Most parents did see the hospitalization serving an ameliorative function, *e.g.*, releasing them of responsibility and of home tensions, and protection of the patient and/or society.").

[63] Murdock, *Civil Rights of the Mentally Retarded: Some Critical Issues*, 48 Notre Dame Lawyer 139-143 (1972).

[64] "It is striking that the method always thought of first is the institution . . . . Of all clinical groups, the mentally retarded are

One study, for example, involving 103 families with Down's Syndrome children, showed parents with more adequate information and understanding about the child's condition were less likely to institutionalize him.[65] Another study of 1,000 New York children whose families were seeking residential treatment in mental health facilities revealed that 72 percent of the children had received no prior psychotherapy; 85 percent no prior casework; 71 percent no prior special education or school services. In a third study 80 percent of institutionalized mentally retarded children had no prior diagnostic work-up performed in the community.[66]

The decision to institutionalize a child has been shown to relate more closely to the characteristics of the family than to the severity of the child's condition or the optimum treatment. Children from broken homes, from homes with substandard incomes, from homes with other physically or mentally ill persons are disproportionately represented in the institutional population, even among the mentally retarded where the etiology of the child's condition is extrinsic to the family situation.[67] Thus, the

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almost the only ones for whom the automatic first choice is the most extensive, most drastic, and most expensive way of providing services."

Leland & Smith, *supra*, at 79. *See also* D.C. Mental Health Association, Focus on Children Under Stress 82-3, 109, 116 (1975).

[65] Stone, *Family Factors in Willingness to Place the Mongoloid Child*, 72 Am. J. Men. Def. 16, 18 (1967).

[66] D. Block & M. Behrens, A Study of Children Referred for Residential Treatment in New York State 43 (Report to the New York State Interdepartmental Health Resources Board, 1959); G. Saenger, Factors Influencing the Institutionalization of Mentally Retarded Individuals in New York City 13 (Report to the New York State Interdepartmental Health Resources Board, 1960).

[67] G. Saenger, *supra*, at 11, 84 (44% noninstitutionalized versus 77% institutionalized children come from broken homes); D. Block & M. Behrens, *supra*, at 32-35 (half of institutionalized children came from multiproblem families, half had mentally ill family members); Appell & Tideall, *Factors Differentiating Institutionalized from Non-Institutionalized Referred Retardates*, 73 Am. J. Men. Def. 424, 429 (1968) (37% institutionalized children versus 14% noninstitutionalized children from broken homes; 62% institutionalized versus 22% noninstitutionalized children from impoverished homes). *See also J.L.* v. *Parham*, *supra*, sl. op. at 15 (50-75% children in Georgia mental institutions had no family or were part of "severely dysfunctional" family units).



decision by parents to place their children in a mental institution is too often a decision made in default of knowledge about or access to other alternatives in the form of community based support services.

### C. Examination by Admitting Personnel at the Mental Facility Does Not Protect the Child Sufficiently from Unnecessary Institutionalization

Given the complex nonmedical reasons for a parent's decision to institutionalize a mentally disabled child,[68] an admitting physician has limited opportunity to act as a check on behalf of the child against unnecessary institutionalization.

In its decisions constitutionally protecting a woman's right to decide whether or not to bear a child, this Court has given weight to the fact that this vital decision is reached with the consultation and medical approval of her physician. *Roe* v. *Wade*, 410 U.S. 113 (1973) and *Doe* v. *Bolton*, 410 U.S. 179 (1973); *Planned Parent-*

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[68] *Cf.* Child Caring: Social Policy and the Institution 112 (D. Pappenfort, *et al.*, eds. 1973):

"One thing that is clear from a variety of statistical data is that both the decision to place a child in an institution and the selection of a type of institution for him are dependent to a great degree on factors other than the needs of the child."

*See also* R. Glasscote, *supra*, at 973, quoting psychiatric program personnel who decided between inpatient and outpatient admissions.

"Diagnosis itself has minor significance. . . . Rather we look to the criteria of the child's daily living situation at home."

*hood* v. *Danforth, supra.*[69] In the present case, however, the physician does not play the traditional role of the chosen confidante and medical counsel of the patient, but rather a more ambiguous one of family or parental consultant or even gatekeeper for the mental facility. As a result, the requirement of due process protections surrounding the decision to institutionalize a child does not in any way interfere with a confidential relationship of child and doctor.

The admitting physician at a mental facility typically sees the child in a single interview in a strange setting under abnormal stress. In such instances, the doctor will have difficulty in gaining the child's confidence and may indeed be hostilely perceived as an agent of the parents;[70] he will rarely be able to make a thorough evalaution or prediction of the child's future behavior from such an interview. Testimony of Dr. Feiner (478-479a); Dr. Kandler (550a); Dr. Armstrong (47a) (typical admitting examination of a child takes 45-60 minutes). As far as past behavior is concerned, he must rely on the parents' and the child's too-often conflicting

[69] *See, however,* the skeptical comments of Justices Stewart and Powell, concurring, in *Planned Parenthood, supra*: "It seems unlikely that she will obtain adequate counsel and support from the attending physician at an abortion clinic, where abortions for pregnant minors frequently take place." 44 U.S.L.W. at 5209.

[70] *See* Lourie & Rieger, *Psychiatric and Psychological Examination of Children,* in 2 American Handbook of Psychiatry 19 (S. Arieti ed. 1974).

> "From the child's viewpoint, his degree of cooperation with the examiner will be very different if he feels the examiner is a benevolent adult, interested in his side of any reported troubles and understanding of his worries, as against his perception of a demanding, punitive, authoritative figure who has the power to recommend significant changes in his way of life . . . . His approach to the examination may limit the amount of information available to the examiner, or obscure his assets and conflict-free areas of functioning, or give a distorted picture of his functioning in other situations."



reports. Dr. Messinger, (630a). Sometimes, too, there are complicating cultural differences between the physician and the child and his family which can influence the examiner's perception of what the child's behavior or responses indicate. Testimony of Dr. Feiner (473-474a).[71] In sum, he will often have great difficulty in accurately assessing the degree, or even the existence, of mental illness or retardation in the child.[72]

The examining phychiatrist or psychologist is also influenced by the admission policies of the institution.

> "In psychiatry more often than in general medicine and surgery, it is policy rather than clinical necessity that determines which admissions are considered appropriate and what type of treatment will be provided."[73]

[71] *See* Joint Commission Report, *supra,* at 267:

> "For example, mentally ill and emotionally disturbed low-income children and youth are often seen as being untreatable by psychiatrists . . . treatment is strongly related to social class, as is the length of treatment and the kind of diagnosis that is given to the person's illness. Lower-class people are less likely to be given intensive psychiatric treatment, more likely to be treated by inexperienced therapists, and more often labelled as psychotic or near-psychotic."

*See also* Roth, *supra* (greater prevalence of stressful events in lower social classes may result in greater labelling of poor people as mentally ill).

[72] *See* Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions,* 62 Calif.L.Rev. 840, 864 (1964); Eisenberg, *A Developmental Approach to Adolescence,* in Readings in Adolescent Development 61 (H. Bernard ed. 1969) ("The clinician must exercise great caution lest he attribute too great a significance to the turbulent but temporary maladaptive patterns manifested by the adolescent. Incorrect diagnostic formulations may lead to social consequences—for example . . . . institutionalization—that will freeze into permanence an otherwise correctible deviation in the growth pattern.").

[73] Richman & Pinsker, *Utilization Review of Psychiatric Inpatient Care,* 130 Am. J. Psychiatry 900, 901 (1973). *See also* Mendel & Rapport, *Determinants of the Decision for Psychiatric Hos-*

Institutions of the same kind in the same area vary widely on admission rates of similar patients. Dr. Kandler (560a). Some physicians and institutions prefer to hospitalize children for diagnosis and formulation of a treatment plan; others prefer to conduct such evaluations on an outpatient basis. Dr. Ingall (599a, 608-609a). Many admitting physicians depend heavily on the referring physician's recommendations; others are more independent. Dr. Messinger (629a).[74]

All too often, admitting physicians cannot provide and are not even aware of the full range of alternatives to

*pitalization*, 20 Arch. Gen. Psychiatry 321 (1969); Rabiner, *et al.*, *The Assessment of Individual Coping Capacities in a Group Therapy Setting*, 45 Am. J. Ortho. 399 (1975) ("few clinical decisions in psychiatry are as difficult to make as those involving hospitalization"; doctor must rely on estimates of patients' "coping capacities" and prediction of demands that will be made on them in the community).

[74] Mendel & Rapport's study, *supra*, showed a significant difference in admission rates between clinicians with less than six months experience and those with three or more years. There was a clear tendency of the less experienced clinicians to lean more heavily toward hospitalization. *See also J.L.* v. *Parham*, *supra*, sl. op. at 40-41:

> "The court is impressed by the conscientious, dedicated state employed psychiatrists who, with the help of equally conscientious, dedicated state employed psychologists and social workers, faithfully care for the plaintiff children to the extent that state furnished resources and facilities permit. Nevertheless, psychiatry according to psychiatrists is still an inexact science as to which there is the opportunity for wide, sincere differences of opinion among psychiatrists. The opportunity for such wide differences of opinion stems initially and primarily from the fact that psychiatry is dependent upon information that comes from the patient and from other people—parents, family, friends, and staff—who themselves have their own personal interests and problems in communication. To suggest, as we here do, that psychiatrists are not infallible is not an indictment of psychiatry. It is simply to say that psychiatrists like all humans are capable of erring. Since they are capable of erring, psychiatrists like parents cannot statutorily be given the power to confine a child in a mental hospital without procedural safeguards. . . ."



institutionalization that would better serve the child's and the family's needs.[75] They are usually able to provide only one kind of service—institutionalized service. They know that if they refuse that service and offer no alternatives, the parent will seek to institutionalize the child elsewhere, or the child will be returned without help to unwilling and resentful parents. Dr. Kandler (560a); Dr. Ingall (602a).

Thus, the admitting physician is in no position to compensate for the parent's conflicting motives or for the unavailability of alternatives—both major factors in unnecessary institutionalization of the child.[76] If the decision to institutionalize a child is to be based primarily or exclusively on the child's needs and best interests, that decision, as in the case of an adult, must be made by someone less involved than the parent or with more information and access to resources than the admitting physician.

[75] *See* Kelly & Menolascino, *Physicians' Awareness and Attitudes Toward the Retarded*, 13 Mental Retardation 10 (Dec. 1975) (study of sample group of pediatricians and general physicians found a large number were unfamiliar with local community based services for mentally retarded children and made no referrals of patients to such services; 80% still recommended institutionalization for some moderately retarded patients).

[76] Fifty-five percent of mental retardation facilities said they retain minor residents they believe could function as well or better in the community in the face of parental objections to their release. Current Trends, *supra*, at 27.

## III. IN VIEW OF THE HARMS OF INSTITUTIONALIZATION AND THE UNRELIABILITY OF PARENTAL DISCRETION AS THE MEANS OF PROTECTING CHILDREN FROM UNNECESSARY INSTITUTIONALIZATION, CHILDREN SHOULD BE ACCORDED A DUE PROCESS HEARING IN AN IMPARTIAL FORUM TO DETERMINE THE NEED FOR INSTITUTIONALIZATION

*Amici* have documented the serious harms attendant upon institutionalization of children and the unreliability of parental decision-making concerning its necessity. These harms, including loss of liberty, stigma and educational interruptions too closely parallel those suffered by children placed in juvenile rehabilitation facilities or suspended from public schools to permit their infliction directly by the state without some form of due process hearing. *In re Gault, supra; Goss* v. *Lopez, supra.*

A somewhat different question is presented, however, when a child's parents or private guardian seek to institutionalize him. In this situation, *amici* recognize that the dangers of institutionalization must be weighed against the legitimate interests of conscientious parents and their professional consultants in meeting genuine emergencies and the need for short-term psychiatric evaluation and treatment for the emotionally disturbed child or for brief specialized training and respite care for the mentally retarded child. This Court has always treated due process as a stricture whose application must be molded to the competing needs and interests involved in the specific factual situation. *See Goss* v. *Lopez, supra,* 419 U.S. 577-584; *Morrissey* v. *Brewer,* 408 U.S. 471, 481, 490 (1972).

*Amici* respectfully submit that the balancing of competing interests in this case require that, with one limited exception, children must be accorded due process



procedures, including a hearing[77] when they are institutionalized by either the state or their parents. The limited exception consists of brief placements of not more than two weeks made by parents for evaluations and respite care of their younger children.

### A. Children Placed in Institutions by State Guardians Deserve Immediate Due Process Protection

When a child is placed in a mental facility by a state guardian rather than by parents, the constitutionally protected interests of family autonomy are not relevant. The situation is indistinguishable from cases in which the state initiates involuntary commitment proceedings against adults or children. *Cf. In re Gault, supra.*[78] And the threats of harm to institutionalized state wards are, if anything, greater than to children admitted by natural parents. State wards are denied both the oversight of natural parents as to their treatment inside the institution and the bridge of their family to the normal world outside the institution. They tend to remain in hospitals longer because of pervasive lack

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[77] *Amici* will not discuss in detail the precise formulation of due process enunciated by the district court. They find the procedures laid down by the court to be reasonable. Appellants apparently do not take issue with those procedures as such, but rather with the decision that due process applies at all to admissions of minors. The new Pennsylvania Mental Health Act, *see* n. 3 *supra,* provides the same due process procedures for admission to the facilities for the mentally ill of children fourteen and above as for adults.

[78] The court in *Gault* found "extraordinary" the notion that a child could be relegated to a juvenile institution without "the procedural regularity and the exercise of care implied in the phrase 'due process'." 387 U.S. at 27-28. State involuntary commitment statutes which require due process hearings can be invoked against children as well as adults. The state may also invoke neglect jurisdiction when it believes that a parent is unjustifiably withholding needed psychiatric treatment from his child. Neglect proceedings, of course, would require a hearing in which the parents (and usually the child) can contest the need for residential treatment.

of adequate community facilities to treat and house them on discharge. *See J.L.* v. *Parham, supra.*[79]

### B. Children Twelve or Older Should Be Accorded Due Process Protections Similar to Adults

The interests of an adolescent approaching adulthood in protecting his liberty and avoiding the detrimental consequences of stigma are so important as to merit the same due process protections as an adult threatened with involuntary commitment.

Legislatures and courts have increasingly recognized the adolescent's claim to legal autonomy. Youths over twelve can commonly choose which parent to live with; they can often obtain medical treatment for contraception, pregnancy, abortion, venereal disease and addiction.[80]

[79] One of the named plaintiffs in *J.L.* v. *Parham* had been in seven foster homes as a neglected child; at age eight he was placed in the state mental hospital. He remained there for five years despite official predictions that he "will only regress if he does not get a suitable home placement, and as soon as possible." *See also,* D. Block & M. Behrens, *supra,* at 16-17, 32-35 (40% of institutionalized children had lived in four or more different homes or institutions prior to admission; less than one-fourth were living in their natural homes at the time of admission).

[80] *See, e.g.,* Stern, *Furnishing Information and Medical Treatment to Minors for Prevention, Termination and Treatment of Pregnancy,* 5 Clearinghouse Rev. 131; Pilpel & Wechsler, *Birth Control, Teenagers and the Law,* 1 Fam. Planning Perspectives 29 (1969); Note, *Parental Consent Requirements and Privacy Rights of Minors: The Contraceptive Controversy,* 88 Harv.L.Rev. 1001 (1975); Note, *The Minor's Right to Abortion and the Requirement of Parental Consent,* 60 Va.L.Rev. 305 (1974). *See also* Worsfold, *A Philosophical Justification for Children's Rights,* 44 Harv.Ed. Rev. 142, 150 (1974); Rodham, *Children Under the Law,* 43 Harv. Ed.Rev. 495 (1974). *Cf. Planned Parenthood, supra,* 44 U.S.L.W. at 5213 referring to:

> ". . . the predicate which underlies all State legislation seeking to protect minors from consequences of decisions they are not yet prepared to make. In all such situations chronological age has been the basis for imposition of a restraint on the minor's



Courts no longer automatically require that a guardian *ad litem* be appointed to represent them in litigation. *Foe* v. *Vanderhoof,* 389 F. Supp. 947 (D. Colo. 1975).

Research into the cognitive and moral development of children also gives credence to the legal claims of adolescents to participate meaningfully in important decisions which affect their future. According to Jean Piaget[81] and others, children from about the age of twelve possess the ability to conceptualize and engage in abstract reasoning and can apply such reasoning to situations in which they are personally involved.[82] And, while parents

> freedom of choice even though it is perfectly obvious that such a yardstick is imprecise and perhaps even unjust in particular cases." (Stevens, J., concurring & dissenting.)

*See also State* v. *Koome,* 84 Wash.2d 901, 530 P.2d 260, 267 (1975) recognizing that the state legislature could create "age limits which do not perfectly correspond with the capacity of minors to act as adults . . . a subjective inquiry into the maturity of each individual minor is a practical impossibility, and any flat age limit is necessarily arbitrary."

[81] *See, e.g.,* J. Piaget, The Moral Judgment of the Child (1965); J. Piaget, The Origins of Intelligence in Children (1952); Piaget, *Intellectual Evolution from Adolescence to Adulthood,* 15 Human Devel. 1-12 (1972); P. Mussen, Adolescent Behavior and Society (1971); J. Flavell, The Developmental Psychology of Jean Piaget (1963).

[82] "All the available evidence on cognitive development and the growth of intellectual abilities suggests that the adolescent's capacity for exercising independent judgment is limited, as compared to the adult's, only by a lack of relevant experience and information. . . . Furthermore, it will often be particularly important to the adolescent that his competence and autonomy be carefully respected. Adolescents are often deeply involved in the process of developing a sense of separate identity, and will be very resentful of parents or other adult authorities who make decisions for them. . . . Adolescents generally react most favorably in situations in which they are given information which they feel is reliable and the opportunity to form their own judgments."

Hearings, *supra* (Jan. 30, 1976) (Testimony of Dr. Luch Ferguson). With retarded young people, there may be a discrepancy

obviously continue to maintain a strong interest in the upbringing of their adolescent children, they must necessarily cede an increasing measure of control over their destinies to the children themselves.[83]

> "Parental authority wanes gradually as the child matures; it does not suddenly disappear at adulthood. Similarly, the ability to competently make an important decision, such as that to have an abortion, develops slowly and at different rates in different individuals. Both law and science have realized that children below voting age are capable of making many important decisions." *State* v. *Koome*, *supra*, 530 P.2d at 266.[84]

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between developmental and chronological age. It is vital, nonetheless, that the preferences of these young retarded persons be accorded due weight in making the decision about institutionalization and that their participation in any hearing be as broad as their abilities allow.

[83] The large majority of children hospitalized for mental illness are over twelve years, whereas a substantial percentage of children institutionalized for retardation are under that age. Statistical Note 115, *supra*, at Table 4 (among admissions under the age of eighteen to state and county mental hospitals in 1973, 0.8% were under 5; 6.9% age 5-9; 29.8% age 10-14; 62.5% age 15-17); Kugel & Wolfsenberger, *supra*, at 437 (half of new admissions to public facilities for retarded between 1960 and 1967 were under age 10); Current Trends, *supra*, at 7, 17 (42% of residents and 67.5% of new admissions in public facilities in 1974 were age 3-21).

[84] *Amici* stress, however, that despite their cognitive maturity, adolescents deserve special consideration in insuring that their exercise of due process rights is meaningful. If they are required to affirmatively request release or the right to counsel on pain of waiver of their rights to a hearing, they may be intimidated or frightened out of exercising their rights; in some cases tranquilizing drugs may make it impossible for them to choose at all. The district court required that children be seen by counsel promptly after admission in order to consult on their situation; *amici* feel that such a requirement for consultation with an independent advocate is absolutely essential. *See, e.g., In re Long*, *supra*, 214 S.E.2d at 629 (hospitalized child need not request release but must be given hearing). Courts in dealing with children in other situations have emphasized that there is a presumption against waiver of their procedural due process rights. *Cf. In re Gault*,



### C. Younger Children Require Due Process Protections Except for Very Brief Periods of Institutionalization

Although children under the age of twelve may not have matured sufficiently to be entrusted with decision-making about their own welfare, they are, if anything, more subject to developmental and emotional harms from unnecessary institutionalization. They are also apt to be less articulate in voicing their grievances and anxieties during institutionalization.

It is true that parental discretion with younger children normally extends to selecting and obtaining medical and psychiatric care from licensed providers, and that such discretion can involve brief residential placements of the child for specialized evaluation or care. But young children have fundamental interests in liberty and protection from developmental harms that deserve safeguarding from prolonged institutionalization. Thus they need due process hearings to insure that they are not unnecessarily institutionalized and segregated from family and community life. In *amici's* view, the proper balance of interests would allow parents of younger children to place them in appropriate residential care facilities for very brief periods of a week or two, at the end of which the due process procedures ordered by the court below would come into force. Where the parents are anticipating only a brief institutionalization for a finite purpose, which cannot be achieved through existing nonresidential

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*supra*, 387 U.S. at 55; *Heryford* v. *Parker*, *supra*, 396 F.2d at 396. And with mental patients, courts have been especially solicitous that they not be forced to affirmatively assert their rights against authorities or be deemed to have waived them. *Covey* v. *Town of Somers*, 351 U.S. 141 (1956); *Moore* v. *Michigan*, 355 U.S. 155 (1957); *Lynch* v. *Baxley*, *supra*, 386 F. Supp. at 396; *Dale* v. *Hahn*, 440 F.2d 633, 638-639 (2d Cir. 1971); *Anderson* v. *Solomon*, 315 F. Supp. 1192, 1194 (D. Md. 1970); American Bar Foundation, The Mentally Disabled and the Law 40, 42 (Lindman & McIntyre ed. 1961).

programs, parental decision-making power deserves to be honored.[85] As the period lengthens into several weeks, however, and the risk of institutional harms and severance of family ties becomes more acute, the child's interests then become preeminent and require the invocation of a due process inquiry into the need for continued institutionalization.

### D. Due Process Hearings Should Not Impede the Delivery of Needed Therapy or Training to Mentally Disabled Children

*Amici* do not believe, as appellants assert, Brief, p. 45, that the child who prevails at a hearing need win only a "Pyrrhic" victory resulting in return to a family which does not want and cannot help him. In fact, families often feel ambivalent and helpless about a disabled child, driven to institutionalization because they do not know what else to do, and are genuinely searching for a resolution that will allow the child to remain with them.

Thus a hearing before an impartial tribunal can fulfill a therapeutic purpose for both parents and child by reviewing the reasons which allegedly justify hospitalization, whether the treatment or training the child needs can be provided outside of the institution,[86] what treat-

[85] The court should, however, recognize the need even in brief evaluative or respite situations, of independent monitoring of the young child's situation to prevent abuse or neglect. *Amici* recommended that all young residents of any mental health or retardation facility be regularly and frequently seen by a representative of an advocacy organization to insure their welfare.

[86] *See also*, A. Stone, Mental Health and Law: A System in Transition 12-14 (1975). Professor Stone argues that in our society institutionalization is generally overused because of the incorrect assumption (or perhaps hope) that "technical" assistance is available when often such expertise is lacking. As a result, we tend to seek scientific solutions where humane care and responsibility are what is needed. Thus, Stone urges a return to family responsibility, rather than increased use of institutionalization.



ment the child will actually receive inside the institution,[87] how long he is expected to be institutionalized, whether and when his natural parents are willing and able to receive him back into their home, and what the child's desires are in the matter. All of these factors would be relevant in deciding whether the child with mental, developmental and/or physically handicapping conditions is in fact "in need of treatment, care or observation." [88] The child's total spectrum of needs for care, safety, treatment, (re)habilitation and emotional warmth has to be examined to decide if residential treatment is indicated.

With a hearing mechanism in place, the choice need not be between institutionalizing a child and returning him to a hostile and helpless family.[89] The decision-maker

[87] Thus, if the institution is substandard or not substantially in compliance with accreditation standards, or not equipped to administer the treatment or training the child needs, the child should not be institutionalized there.

[88] The lower court did not pass on the proper standard for commitment for a minor. The Pennsylvania statute providing for voluntary commitments uses criteria of "in need of treatment, care, or observation." Many federal and state courts have, however, required a stricter standard of dangerousness to self or others for involuntary commitments. *See* n. 9, *supra*.

[89] Experts agree that the majority of children presently institutionalized could be treated in the community if sufficient programs existed. Joint Commission Report, *supra*, at 266-267 ("most communities have programs even for a portion of the population. . . . In those few communities where most of these services are available, the programs tend to be fragmented . . . the very poor, who need these services most, have least access to them"). (1) Daytime and partial-hospitalization programs have proven successful for many mentally ill and retarded children as an alternative to institutionalization. *See, e.g.*, Fenichel, *A Day School for Schizophrenic Children*, 30 Am. J. Ortho. 130 (1960); R. Glasscote, Partial Hospitalization for the Mentally Ill (American Psychiatric Association and National Association for Mental Health Joint Information Service (1969); Jubenville, *A State Program of Day Care Centers for the Severely Retarded*, Community Services for

in such a hearing can explore the family situation. He may arrange appropriate treatment for the child and/or the family. When only the child is institutionalized, the family's critical role in the treatment or training process is too often neglected.[90] A hearing officer can also order a thorough review of existing community alternatives and may even mandate the creation of these sorely needed

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Retarded Children: The Consumer-Provider Relationship (Dempey ed. 1975). (2) Community services for the families of these children have also reduced the need for institutionalization. M. Gula, Child Caring Institutions: Their New Role in the Community Development of Services 19 (HEW 1958). (3) Specialized foster care programs for mentally ill and retarded children have been established in several states. Wolfensberger, *A New Approach to Decision-Making in Human Management Services,* in Changing Patterns in Residential Services for the Mentally Retarded, *supra,* at 379 (1969); O'Regan, *Foster Family Care for Children With Mental Retardation,* 3 Children Today 21 (1974); Garrett, *Foster Family Services for Mentally Retarded Children,* in Community Services for Retarded Children, *supra,* at 248; Simmons, *et al., Natural Parents as Partners in Child Care Placement,* 54 Social Casework 224-232 (1973). (4) Finally, group homes provide a substitute for mentally ill or retarded adolescents. M. Gula, Agency Operated Group Homes 1 (HEW 1964); Mosher, *et al., Soteria: Evaluation of a Home-Based Treatment for Schizophrenia,* 45 Am. J. Ortho. 465 (1975). *See also* McCormick, Ballam & Zigler, *Resident Care Practices in Institutions for Retarded Persons: A Cross-Institutional, Cross-Cultural Study,* 80 Am. J. Men. Def. 1416 (1975) (small community based settings for retarded persons are characterized by more resident-oriented care practices; the number of residents per living unit is more determinative of individualized care than the staff-resident ratio).

Nebraska has been able to reduce its population of institutionalized retarded persons dramatically by a continuum of community care services, including special foster homes, intensive-training group homes, five-day hostel residences for family respites; Glenn, *supra,* at 505-514; Wolfensberger & Menolascino, *Reflections on Recent Mental Retardation Developments in Nebraska,* 8 Mental Retardation 20 (1970).

[90] *See, e.g.,* Testimony of Dr. Messinger (621a) ("if there are going to be real changes in that child, there have to be concomitant changes in the family"); Joint Commission Report, *supra,* at 112-113, 263.



resources.[91] He can insist that the child be provided with the services by public agencies when the family has been frustrated by bureaucratic delays. Hearings can also satisfy a child's inherent sense of fairness and his need to be heard when he feels strongly that he is being dealt with unjustly.[92] Even in those cases where hospitalization is necessary, the hearing can relieve parents of the burden of unilateral action. Testimony of Dr. Messinger (623a, 625a, 636-638a); Dr. Feiner (480a, 483a, 484a, 494-495a); Dr. Kandler (561a, 567-568a, 574-576a). And a hearing may improve the relationship between the child and the professional therapist. Once he has had a full hearing, the child may become more cooperative in the treatment plan. Testimony of Dr. Kandler (561a, 574-576a); Dr. Messinger (633a). The therapist will perhaps no longer be perceived as a co-conspirator with the parents in committing the child. Testimony of Dr. Kandler (593-594a); Dr. Ingall (612-613a); Dr. Messinger (624a).

Several studies suggest that an opportunity for juveniles to contest institutionalization at hearings will not necessarily interfere with therapy. Encouraging active participation of the patient in decision-making about his own future is both a tenet of psychotherapy and a maxim of "normalization" for the mentally retarded.[93] Adoles-

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[91] *See, e.g., J. L.* v. *Parham, supra,* sl. op. at 43 (court order to "provide necessary physical resources and personnel for whatever non-hospital facilities are . . . most appropriate for these children").

[92] *Cf. In re Gault, supra,* 387 U.S. at 26.

> "[T]he appearance as well as the actuality of fairness, impartiality and orderliness—in short, the essentials of due process—may be a more impressive and more therapeutic attitude so far as the juvenile is concerned."

[93] *See, e.g.,* Tucker & Maximen, *The Practice of Hospital Psychiatry: A Formulation,* 130 Am. J. Psychiatry 889 (1973).

> "In the design of a hospital program it is . . . essential to create an atmosphere that encourages patients to take active

cent as well as adult mental patients very often have a realistic notion of whether they need hospitalization.[94] And they have apparently exercised their existing limited rights to object to hospitalization in a way that has not been unduly disruptive of hospital routine.[95]

In sum, the rational application of due process to the commitment of children can help to decrease unnecessary and damaging institutionalization [96] and to bring to bear

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responsibility for themselves and others. In other words, instead of being the passive recipients of the staff's therapeutic efforts, the patients should assume the role of change agents."

*See also* NARC, Policy Statements on Residential Services, *supra*, at 4 (need for the mentally retarded person to have "involvement in decisions affecting oneself").

[94] In one study, patient and staff judgments agreed on the avoidability of hospitalization in two-thirds of the cases studied if alternative treatment were available in the community. This ratio was not significantly different for adolescent patients (over fourteen) than for adults. The study concluded:

> "Judgments made by patients, even though they are acutely disturbed, are much more valid . . . than might have been expected. . . . The clinical significance of this is that the psychiatrist deciding upon admission versus alternative treatment can validly take into account the opinion of the patient."

Lipsius, *Judgments of Alternatives to Hospitalization*, 130 Am. J. Psychiatry 892, 895 (1973).

[95] Meisel, *Due Process in the Civil Commitment of Children*, 10 Psychiatric Spectator 5-6 (1975).

[96] Estimates vary as to how many children in mental hospitals and retardation institutions would not be there if community based services were adequate. A federal court recently cited a study that "more than half" of Georgia's juvenile mental inpatients "would not need hospitalization if other forms of care were available", *J.L.* v. *Parham*, *supra*, sl. op. at 13. The Department of Health, Education and Welfare cites studies showing only one-third of the children in St. Elizabeths Hospital and in 20 Texas mental hospitals need hospitalization. Statistical Note 115, *supra*, at 4. A survey of public retardation facilities showed that lack of community services was the primary reason given for 50% of readmissions to such facilities in 1974. The directors estimated that the total residential population could be decreased by 52% if community services were adequate. Current Trends, *supra*, at 20, 23.



on the unfortunate situation of disturbed and retarded children the attention and community resources they require.

## CONCLUSION

For the reasons set forth above, *amici* urge this Court to affirm the judgment of the court below insofar as it applies due process procedures to children admitted to mental facilities. In the case of younger children, a limited exception should be made for brief periods not to exceed two weeks when they are placed by parents in residential facilities for evaluation or respite care.

Respectfully submitted,

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* Counsel for *amici* gratefully acknowledge the assistance of Gail Marker, M.S.W., for her invaluable assistance in the preparation of this Brief.

IN THE SUPREME COURT OF THE

UNITED STATES

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No. 75-1064

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JACK B. KREMENS, ET AL.,
*Appellants*

v.

KEVIN BARTLEY, ET AL.,
*Appellees*

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CERTIFICATION OF SERVICE

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I, Paul R. Friedman, hereby certify that on August 3, 1976, I served by mail one copy of the foregoing Brief for *Amici Curiae* on David Ferleger, Esquire, 2321 Sansom Street, Philadelphia, Pennsylvania 19103, Counsel for Appellees, and on Norman J. Watkins, Esquire, Capitol Annex Building, Harrisburg, Pennsylvania 17120, Counsel for Appellants.

Paul R. Friedman

Supreme Court, U. S.
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# In the Supreme Court
OF THE
# United States

OCTOBER TERM, 1976

**No. 75-1064**

JACK B. KREMENS, et al.,
*Appellants,*

vs.

KEVIN BARTLEY, et al.,
*Appellees.*

**Appeal from the Judgment of the United States District Court for the Eastern District of Pennsylvania**

## BRIEF OF THE YOUTH LAW CENTER AS AMICUS CURIAE IN SUPPORT OF APPELLEES

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# In the Supreme Court
OF THE
# United States

OCTOBER TERM, 1976

No. 75-1064

JACK B. KREMENS, et al.,
*Appellants,*

vs.

KEVIN BARTLEY, et al.,
*Appellees.*

**Appeal from the Judgment of the United States District Court for the Eastern District of Pennsylvania**

## BRIEF OF THE YOUTH LAW CENTER AS AMICUS CURIAE IN SUPPORT OF APPELLEES

### INTEREST OF AMICUS CURIAE[1]

The Youth Law Center, a legal services program funded principally by the federal Legal Services Corporation, was created in 1970 for the express purpose of promoting reform of the law in the area of children's rights and juvenile law. Primarily concerned with the status and needs of children and adolescents in this society, Center attorneys have represented

[1]Written consent for the filing of this Brief *Amicus Curiae* in the form of letters from counsel both for Appellants and for Appellees, pursuant to Supreme Court Rule 42(2), have been filed with the Clerk of this Court under separate cover.

young persons in numerous cases dealing with their constitutional and statutory rights. Youth Law Center attorneys have also appeared as counsel before this Court on behalf of children in cases dealing with juvenile court proceedings [*Breed v. Jones,* 421 U.S. 519 (1975)] and with public education [*Lau v. Nichols,* 414 U.S. 563 (1974)]. Moreover, Center attorneys have appeared on behalf of children in California appellate courts, including the California Supreme Court, regarding their placement in state mental hospitals through the action of juvenile courts [*In re Michael E.,* 15 Cal.3d 183, 538 P.2d 231, 123 Cal.Rptr. 103 (1975); *In re L.L.,* 39 Cal.App.3d 205, 114 Cal.Rptr. 11 (1974)], as well as through parental action such as in the present case [*In re Paul J.B., petition dismissed,* 1 Crim. 14811 (Cal. Ct. App., Dist. One, Div. One, June 30, 1976)]. The Youth Law Center also appeared as *amicus curiae* in the District Court in the present action. (Brief filed October 4, 1973; Appendix 2a).

*Amicus curiae* thus brings to this action a long-standing familiarity with the issues in this case as well as in similar cases. *Amicus* believes that the issues raised in this case present important questions of national significance, questions which are of obvious concern to children everywhere, not only to the children of Pennsylvania. *Amicus* believes that by its participation in this action it can bring before this Court considerations which will assist the Court in deciding the important questions raised by this appeal.



## SUMMARY OF ARGUMENT

In the United States today, children and adolescents constitute a greater proportion of the total number of patients residing in mental hospitals than at any previous time during the last twenty years. Adolescents are being kept in mental hospitals for longer periods of time than are older patients, and disproportionately fewer adolescents receive alternative psychiatric care before being confined for treatment. In *Amicus'* opinion, these statistics raise the concern that too many children may presently be confined in mental hospitals and that for many of these children non-institutional care should first have been considered, but was not.

*Amicus'* concerns are deepened by the absence of due process safeguards available to minors who are placed in mental institutions by their parents or legal guardians. Under Pennsylvania law minors may be placed in mental hospitals subject only to the concurrence of a local medical facility or mental health agency and the admitting hospital. The absence of any requirement of a prior, or prompt, due process hearing is in distinct contrast to this Court's requirement of full due process procedures before minors may be committed to youth training schools through the juvenile justice system. *In re Gault,* 387 U.S. 1 (1967).

As *Amicus* will show, many children who commit deviant or anti-social conduct but are mentally ill are channelled to treatment facilities by juvenile courts. A juvenile court's jurisdiction over these

youngsters is quite extensive under statutes which cover not only delinquency, but also dependency and "status offenses." As the record in the present case shows, many members of appellees' class had committed delinquent behavior or other acts which clearly would have fallen within juvenile court jurisdiction. Under Pennsylvania law and this Court's decision in *Gault,* if these children had been taken to juvenile court, they would have been entitled to full due process hearings. Instead, through utilization of alternative procedures which are also designed to provide rehabilitative treatment, but which by-pass the due process procedures available in juvenile courts, appellees have been deprived of due process protections to which they would otherwise have been entitled. Such deprivation constitutes a violation of the Equal Protection Clause of the Fourteenth Amendment.

In *Amicus'* view, the analogy between *Gault* and the present case is especially compelling because appellees here are subject to severe and massive deprivations of numerous constitutional rights just as are juveniles who are committed to training schools. These rights include liberty, privacy, and freedom of association—rights which are fundamental under our Constitution. Also like Gerald Gault, appellees are being confined for an indefinite time for the purpose of providing them with treatment, although many studies and scholarly articles confirm the *Gault* analogy: the promise of meaningful treatment for mentally disturbed or disordered juveniles is too frequently illusory. Unfortunately, many minors confined in



mental institutions are at best exposed to protective custody; at worst they live under brutalizing and inhumane conditions. Hence, unless there is some constitutionally adequate justification for treating appellees here differently from children in juvenile courts, appellees should receive the same due process protections mandated by *Gault.*

This Court has established that children are protected by the Due Process Clause of the Fourteenth Amendment; moreover, only a compelling reason may justify a state's deprivation of the fundamental right to liberty which is protected by that Clause. In the present case, the principal interests asserted by appellants are preservation of family unity and maintenance of parental authority. However, as this Court recently recognized in *Planned Parenthood of Central Missouri v. Danforth,* 44 U.S.L.W. 5197 (U.S. July 1, 1976), these goals are unlikely to be promoted by a scheme which denies even mature and competent minors legitimate participation in decisions vitally affecting their interests. In addition, as is implicitly suggested by *Planned Parenthood,* the parents' interests in family unity and harmony do not outweigh the child's right not to be involuntarily institutionalized and not to be stigmatized as mentally ill without a judicial hearing. When a parent seeks to place his child outside the family structure, the parent necessarily abrogates some of his normal freedom to be free from state scrutiny. In placing their children in mental hospitals, many parents are responding to familial difficulties to which the parents themselves

may be contributing and in which they are, in any event, participants. At such times and under such circumstances even the best-intentioned parent may find it difficult to make a rational decision about how to cope with intra-family strife. The potential, and frequently actual, conflict of interest between a child and his parents in such times of stress has caused a number of courts to hold that the distinct interests of the child in cases such as this can only be safeguarded in a judicial hearing at which the child is represented by independent counsel.

Appellants have also contended that referral to a mental hospital by a medical facility or mental health center is an adequate substitute for due process procedures. However, physicians are neither trained nor equipped to balance the mental health needs of patients against their civil liberties. Moreover, most psychiatrists have a quite natural bias which leads them to err in favor of committing healthy persons to mental hospitals rather than risking the error of allowing mentally disordered persons to go free. Given the time and resource constraints which frequently make comprehensive psychiatric evaluations impracticable, the psychiatrist tends to support the parent who has already concluded that his child needs hospitalization.

Finally, although Pennsylvania has now adopted regulations which accord minors over the age of thirteen some due process rights, these regulations are insufficient to ameliorate the defects in Pennsylvania's statutory scheme. The regulations do not



provide for a probable cause hearing, nor do they specify any time period within which a post-commitment hearing must be conducted. The regulations do not guarantee minors such due process protections as the right to counsel, cross-examination and confrontation of opposing witnesses, or a "clear and convincing evidence" standard of proof. Finally, the regulations deny even those minors who are mature and competent the right to volunteer themselves for treatment or to obtain treatment without parental consent. Hence, none of appellants' justifications for failing to provide due process protections to the children who are appellees in this case are sufficient to overcome the constitutional requirements which have been established by this Court and which are fully applicable here.

---

## ARGUMENT

### I. ADOLESCENT POPULATIONS IN MENTAL HOSPITALS ARE NOT DECLINING AS MUCH AS ARE OTHER AGE GROUPS, ADOLESCENTS ARE BEING KEPT IN SUCH HOSPITALS FOR PERIODS OF TIME LONGER THAN OTHER AGE GROUPS, AND DISPROPORTIONATELY FEWER ADOLESCENTS RECEIVE ALTERNATIVE PSYCHIATRIC CARE BEFORE BEING PLACED IN SUCH HOSPITALS.

This case raises significant issues affecting a large number of children and adolescents throughout the United States.[2] In fact, children and adolescents con-

[2] In 1973, the last year for which national statistics are available, a total of 10,576 children and adolescents under 18 years of age were resident patients in State and county mental hospitals in the United States. National Institute of Mental Health, Div. of Biometry, Statistical Note 113, Table 2a at 8 (Public Health Service Pub., February, 1975).

stitute a greater proportion of the total number of persons residing in mental hospitals in the United States today than at any previous time within the past twenty years. This increase has occurred although national policy has placed increasing emphasis in recent years on the use of community programs in place of hospitals for the mentally ill and mentally retarded.[3] Since 1950 and especially during the past decade, the number of adults in state and county mental hospitals has plummeted so that there were 55% fewer persons age 25 and over in such hospitals in 1973 than there were in 1950. At the same time, the percentage of children in state and county mental hospitals has increased, resulting in a 332% increase in the number of children under age 15 placed in mental hospitals between 1950 and 1973, and a 28% increase in the number of young persons between the ages of 15 and 24 so placed during the same period of time.[4] It is important to note that the "under age

[3]*See, e.g.*, Community Mental Health Centers Amendments of 1975, Pub. L. 94-63 Title III §302(a)(1): "[c]ommunity mental health care is the most effective and humane form of care for a majority of mentally ill individuals;" Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C.A. §6032(b): giving "special consideration to applications for grants" that demonstrate "an ability and commitment to provide within a community rather than in an institution services" for the developmentally disabled; Special Health Revenue Sharing Act of 1975, 42 U.S.C.A. §246(d)(2)(D)(i)(I): State plans must be "designed to eliminate inappropriate placement in institutions of persons with mental health problems."

[4]These percentage increases do not reflect certain variations which have taken place during the more recent years. "Nationally, the resident population [including adults] of State and county mental hospitals has been declining since 1956. In the interval from 1967-1973, the number decreased from 426,309 to 248,518, a decrease of 42%. The under 18 age group experienced slight *increases* each year from 1967 to 1970, but beginning in 1971, the *number* of residents under 18 has decreased each year, as has the rate per 100,000 population." National Institute of Mental Health, Div. of Biometry, Statistical Note 113, at 1 (Public Health Service Pub., February, 1975) (emphasis added). In spite of these more recent decreases in the whole number of young persons under age 18 in mental hospitals, referred to in Statistical Note 113, the proportion of such persons has continued to climb as compared with all other ages. Thus, although those under 18 constituted only 2.8% of the resident patient population of state and county mental hospitals in 1967, that figure had steadily climbed to 4.3% by 1973. *Compare,* National Institute of Mental Health, Div. of Biometry, Statistical Note 113, Table 2 at 7 (Public Health Service Pub., February, 1975), *with id.,* Table 2a at 8.



15" group does not include very many children who are under age 10. In fact, from 1969 through 1973, of those children under age 18 who were admitted to or resident in state and county mental hospitals, almost all were between the ages of 10 and 17. The actual percentages are as follows:[5]

| | *Under age 10* | *Age 10-17* |
|---|---|---|
| 1969 | 8.6% | 91.4% |
| 1970 | 6.8% | 93.2% |
| 1971 | 7.3% | 92.7% |
| 1972 | 6.9% | 93.1% |
| 1973 | 7.7% | 92.3% |

In addition to constituting an increasing percentage of the resident population of mental hospitals, young persons under 18 years of age remain in mental hospitals longer than do other age groups. For example, in state and local mental hospitals in 1971, the median number of days of stay was seventy-two (72) for those under 18 years of age and only forty-one (41)

[5]National Institute of Mental Health, Div. of Biometry, Statistical Note 115, Table 4 at 12 (Public Health Service Pub., April, 1975).

for all ages combined. Additionally, in private mental hospitals in 1970, the median number of days of stay for those under 18 years of age was thirty-four (34) as compared with twenty (20) days for all ages combined.[6]

A third characteristic of young persons in mental hospitals is that they have rarely received previous psychiatric care before being placed in such hospitals. Statistics available from 1969 reveal that well over half (53.5%) of the young persons under age 18 had received no previous psychiatric care before being placed into state and county mental hospitals, whereas, in contrast, only 38.7% of *all* admissions (a statistic which includes the under age 18 population as well as all others) had failed to receive prior psychiatric care before being so admitted.[7] Hence, it cannot be said that young persons are generally receiving alternative psychiatric services before being placed in mental hospitals.

Although these statistics do not resolve the important legal issues which are central to this case, they do provide cause for concern, in *Amicus'* view, that too many children may be found in mental hospitals

[6]National Institute of Mental Health, Div. of Biometry, Statistical Note 90, Table 8 at 14 (Public Health Service Pub., July, 1973). These ratios do not maintain to general hospital in-patient psychiatric units where the number of days of stay are ordinarily very short. In such units, the median for all ages is slightly higher than the median for the under 18 years of age group (11.4 as opposed to 9.7).

[7]National Institute of Mental Health, Div. of Biometry, Statistical Note 90, Table 9 at 15 (Public Health Service Pub., July, 1973).



in the United States today, that they may be kept in such hospitals for too long a time, and that they may not be receiving access to the alternative sources of psychiatric care which are generally regarded as being both appropriate and necessary for the treatment of mentally disturbed or handicapped persons. *Amicus* believes that the due process protections discussed hereinafter will do much to assure that these concerns will at least be considered before a child is placed in a mental hospital, and that without such due process protections there can be no guarantee that children will not continue to be placed in mental hospitals inappropriately.

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## II. MANY CHILDREN ARE PLACED IN MENTAL HOSPITALS AS AN ALTERNATIVE TO THEIR PLACEMENT IN TRAINING SCHOOLS BY JUVENILE COURTS.

### A. The Jurisdiction of Juvenile Courts Extends to Many of the Children Who are the Subjects of this Action.

One of the principal bases of juvenile court jurisdiction is "status offenses," offenses only for children. President's Commission on Law Enforcement and Administration of Justice, *Task Force Report: Juvenile Delinquency and Youth Crime* 25 (1967). "Status offenses" commonly include within their definition behavior which is directly related to the relationships between juveniles and their parents. A typical "offense" is to be "beyond reasonable parental control." Levin and Sarri, *Juvenile Delinquency: A Comparative Analysis of Legal Codes in the United States*

11 (National Assessment of Juvenile Corrections, 1974).[8] Thus, appellants' contention in this case that the purpose of juvenile court proceedings is "to determine 'did he do it,'" is not correct with regard to a major portion of juvenile court jurisdiction. (Brief for Appellants at 40) Indeed, the determination to be made by the juvenile court is very similar to the determination to be made regarding the placement of children in mental hospitals in the present case. This is because the justification for incarceration of juvenile offenders in this country is their need for "rehabilitative treatment." In fact, in some states[9] a juvenile who does not need treatment is not even subject to the jurisdiction of the juvenile court at all. However, even in those states where the need for treatment is not actually jurisdictional, the purpose of juvenile court jurisdiction is to provide treatment to the offender, ". . . to provide for the care, protection and wholesome mental and physical development of children . . . ." Pa. Stat. Ann. tit. 11, §50-101(b)(1).

Hence, although there are some children in mental hospitals in this country who are seriously emotionally disturbed, for many of the children who are

[8]*See, e.g.*, Cal. Welf. & Insts. Code §601(a): "Any person under the age of 18 years who persistently or habitually refuses to obey the reasonable and proper orders or directions of his parents, guardian, or custodian, or who is beyond the control of such person is within the jurisdiction of the juvenile court which may adjudge such person to be a ward of the court." Pa. Stat. Ann. tit. 11, §50-102(a): "'delinquent act' means: . . . (ii) a specific act or acts of habitual disobedience of the reasonable and lawful commands of his parent, guardian, or other custodian committed by a child who is ungovernable."

[9]*E.g.*, N.Y. Family Court Act §§731(c), 732(c) (McKinney, 1962).



under consideration here, placement in a mental hospital has been utilized as an alternative to juvenile court proceedings. If those children had been processed as "status offenders" by juvenile courts, they would have been subject to incarceration in much the same fashion, and often in the same institutions[10] as are juvenile delinquents who have committed criminal offenses. In 1974, for example, 23% of the males and 70% of the females incarcerated in juvenile correctional institutions in the United States were status offenders.[11]

**B. Many of the Children in this Case Are Identical to Children Who Come Within the Jurisdiction of Juvenile Courts.**

Because juvenile court laws and "voluntary" commitment statutes are exceedingly broad and share the same beneficent purposes—to provide treatment to juveniles—there are many children in state training schools who would have been likely candidates for placement in mental hospitals just as there are children in mental hospitals who might equally have been the subject of juvenile court proceedings.[12] For example, in *Morales v. Turman*, 383 F.Supp. 53 (E.D. Tex.

[10]*See*, Knudten, *Crime in a Complex Society*, Chap. 22 (1970); Sheridan, "Juveniles Who Commit Non-Criminal Acts: Why Treat Them in the Correctional System?" 31 *Federal Probation* 27 (1967).

[11]Hearings on S-821 Before the Subcomm. to Investigate Juvenile Delinquency of the Senate Comm. on the Judiciary, 94th Cong. 1st Sess., Appendix, pt.4 at 523, 525 (1976).

[12]The actual "Reasons for Admission" of children in the present case include such things as "violation of probation" (Steve Willett, 165a); "10 day evaluation at request of court" (Elizabeth Schriber, 164a); "Court—Stealing cars" (David Rhinehart, 163a); "charges of assault & battery while at Sleighten Farm" (Anita Jenkins, 162a); "Behavior problem: Sexual acting out, foul language,

1974), a case concerning juvenile training schools in Texas, the court found that a significant population of the training schools (372 juveniles) was "seriously emotionally disturbed" and that another large group of children (209 juveniles) in the institutions had "intelligence quotients recorded as lower than seventy." 383 F.Supp. at 88-89. In the case of *Martarella v. Kelley,* 349 F.Supp. 575, 591 (S.D.N.Y. 1972), the court quoted New York Family Court Judge Florence Kelley regarding status offenders: "I think some of our most seriously disturbed children are the ones who come in as alleged persons in need of supervision." In *Lollis v. New York State Dept. of Social Services,* 322 F.Supp. 473 (S.D.N.Y. 1970), the 14 year old plaintiff had been confined in the Brockwood Annex of New York's Hudson Training School for Girls for allegedly threatening her mother with a knife. Identical behavior in the present case precipitated the commitment of Leslie Levine to the Haverford State Hospital. (166a-168a) Mark Weand, who was also committed to Haverford State Hospital, had engaged in similar, though perhaps more serious behavior: he allegedly tried to kill his uncle with a knife while under the influence of drugs. (168a-171a)[13]

physically abusing stepmother, running away, crashing family car, drugs" (Benjamin Mosco, 151a); "Rebellion, aggressive behavior. Runaway, threatening to take drugs. Refusing out-patient care" (Mary Lou Gallagher, 144a); "PT [patient] excluded from mother's home; previous drug use; previous admission to this hospital" (Nancy Brehm, 138a); "3 wks. of truancy; 3 days of uncontrollable behavior; threatened suicide" (Willard Burnett, 136a).

[13]It should be noted that, in general, the ages of the children who are incarcerated in mental hospitals and who are the subject of this action, *see* pp. 8-9, *supra,* are approximately the same age as



One commentator has described the relationship between mental illness and juvenile delinquency as follows:

> . . . [S]tandards of deviance and acceptability are relative. . . . The same behavior may, depending upon the situation, be considered socially acceptable, mentally ill, or criminal . . . .
>
> For example, an adolescent who commits a car theft may confess to a policeman, be called a juvenile delinquent and be jailed. He may instead consult a psychiatrist and then he is likely to be labeled mentally ill and receive psychotherapy. . . . J. Zusman, "Society and Mental Illness," 15 *Arch. Gen. Psychiatry* 635, 636-37 (1966).

The testimony of experts in the present action underscores the relationship between the children and adolescents who are incarcerated in mental hospitals and those who are made subject to the juvenile court.

the children incarcerated in state training schools for juvenile delinquents and status offenders. *See* U.S. Law Enforcement Assist. Admin., Dep't of Justice, *Children in Custody,* Tables 9 and 10, at 12 (1971). Those tables show that no juvenile training schools held any children below age 6, only 9 training schools held any children below age 9, 47 training schools held children below age 12, and a total of 124 training schools had no children who were not at least 12 years of age. Although available statistics regarding the ages of children in mental hospitals are not distributed along exactly the same lines as in the training school report just referred to, it is instructive to note that in addition to the information set forth at page 9, *supra,* between 60 and 65% of the children in mental hospitals during the years 1969 through 1973 were between 15 and 17 years of age. National Institute of Mental Health, Div. of Biometry, Statistical Note 115, Table 4 at 12 (Public Health Service Pub., April, 1975).

The testimony of Dr. D. H. Miller, an adolescent psychiatrist who testified on behalf of appellants, is instructive:

> We have a policy in our hospital of open admissions and if we have a space we will admit someone.
>
> . . . We get children referred to us by parents directly. Sometimes by the juvenile court, sometimes by parents via some pressure from the school system, pediatrician or another psychiatrist.
>
> . . .
>
> . . . We will admit boys and girls sometimes under conditions which would certainly not fit the adult commitment laws in Michigan. (682a-83a).
>
> . . .
>
> We take youngsters who repeatedly run away from home and put themselves in danger by exposing themselves to who knows what and so on. (697a).

Dr. E. C. Messinger testified on behalf of appellees that "in practical terms, the institution that usually blows the whistle on trouble for a child is the school, because of truancy, academic failure, misbehavior in the school."[14] (620a) Finally, a document which was submitted by appellees in the District Court in this action described in detail "the reasons juveniles are institutionalized in the mental facilities in Pennsyl-

[14]School problems, especially truancy, constitute one of the principal bases of a juvenile court's "status offense" jurisdiction. *See* Levin and Sarri, *Juvenile Delinquency: A Comparative Analysis of Legal Codes in the United States,* 11-12 (National Assessment of Juvenile Corrections, 1974).



vania." (210a) That document, entitled "Incarcerated Juveniles—Why? The Mental Institutionalization of Juveniles in Pennsylvania," fully demonstrates what is contended here: placement of children and adolescents in mental hospitals is utilized by many parents as an alternative to referring those children to a juvenile court for disposition.[15]

### C. Utilization of the "Voluntary" Commitment Process Instead of Providing the Due Process Procedures Available in Juvenile Court Proceedings Violates the Rights of the Children in this Case.

As has been shown, "status offenders" are subject to incarceration in juvenile training schools following adjudication by juvenile courts. They are also entitled to substantially the same due process protections in juvenile courts as are children who have been charged with criminal law violations. *In re Gault,* 387 U.S. 1 (1967). However, the present case demonstrates that unlike children who are adjudicated by juvenile courts, children who are placed in mental hospitals by their parents receive no due process pro-

[15]"Today courts and legislatures cooperate to punish summarily children who disobey their parents . . . . Under [such statutes], parents usually are the complainants . . . .

. . .

"The effect of the mistakes undoubtedly made on the side of parents in enforcing disobedient child law probably is very substantial. A very high proportion of those adjudicated juvenile delinquents, especially among girls, are so adjudicated under disobedient child laws. One purpose of making criminal such behavior as disobeying parents is to cast a wide net in order that the juvenile court may rehabilitate youths before they become habituated to criminal behavior." Klienfield, "Balance of Power Among Infants, Their Parents, and the State, Part II," 4 *Family L.Q.* 410, 436-37 (1970) (footnote omitted).

tections whatsover. Moreover, many of those children are identical to "status offenders" from the standpoint of the behavior[16] which leads to their placement in a mental hospital. Furthermore, the purpose of confinement in a juvenile training school is the same as the purpose of confinement in a mental hospital: the provision of treatment to beneficially affect the juvenile's behavior.

In very similar circumstances, this Court has held that a state may not bypass or ignore due process procedures in confining persons in institutions designed to provide them with treatment when it provides similarly situated persons with more stringent procedural protections. *Jackson v. Indiana,* 406 U.S. 715 (1972). Such discriminatory application of due process protections violates the Equal Protection Clause of the Fourteenth Amendment. *See Humphrey v. Cady,* 405 U.S. 504 (1972). *Baxstrom v. Herold,* 383 U.S. 107 (1966). These cases establish that when the state has created procedures that provide judicial hearings and other due process protections to a group of persons—such as "status offenders"—in order to confine them in institutions designed to provide them with treatment, it may not permit the confinement of a substantially similar group of persons—such as the children who are appellees in this case—through utilization of an alternative route that

[16]"We have to remember that in psychiatry, except for neurological diseases, we are dealing with behavior and the behavior that we are most concerned with is social behavior. That is how an individual influences or affects another." Testimony of Dr. E. C. Messinger (628a).



fails to provide those same protections. Hence, by permitting a parent to make the choice of (1) taking a child directly to a mental hospital for placement, subject only to having been referred by a mental health facility and having the hospital administrator approve the incarceration, or (2) taking a child to a juvenile court where the child will receive the representation of a lawyer, a judicial hearing, and all of the elements of a full due process proceeding before being placed in a treatment institution, Pennsylvania has unconstitutionally discriminated against appellees in this case.

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## III. INCARCERATION IN A MENTAL HOSPITAL IS A DEPRIVATION OF LIBERTY NO LESS SERIOUS THAN INCARCERATION IN A TRAINING SCHOOL FOR DELINQUENT JUVENILES.

### A. Children are Protected in Their Liberty by the Due Process Clause of the Fourteenth Amendment.

In a succession of cases, this Court has affirmed the now incontrovertible proposition that children fall within the ambit of the Due Process Clause of the Fourteenth Amendment. *Goss v. Lopez,* 419 U.S. 565 (1975); *In re Gault,* 387 U.S. 1 (1967); *Kent v. United States,* 383 U.S. 541 (1966); *see, Tinker v. Des Moines Independent School District,* 393 U.S. 503 (1969) (First Amendment applicable to children); *Breed v. Jones,* 421 U.S. 519 (1975) (Fifth Amendment double jeopardy provisions applicable to children). As was observed in the landmark decision of *In re Gault,* the word "person" in the Due Process Clause is not limited to adults, for "neither the Four-

teenth Amendment nor the Bill of Rights is for adults alone." *In re Gault, supra,* at 13.

The due process protections of the Fourteenth Amendment have been extended to children both in what might be considered quasi-criminal proceedings, *e.g., In re Gault, supra; Kent v. United States, supra,* as well as in clearly non-criminal circumstances, *e.g., Goss v. Lopez, supra.* In *Goss v. Lopez* this Court specifically required that due process be provided to protect children's non-*de minimis* interests by holding that the state could not deprive a child of his statutorily derived right to attend school for even a few days without providing the child with notice and an opportunity to be heard. Hence, the applicability of the procedural safeguards of the Due Process Clause to the present case, where the threatened injury clearly exceeds the injury of a brief school suspension as in *Goss v. Lopez, supra,* should be readily apparent.

Assuring the protection of due process rights in the present case is especially appropriate because there can be no suggestion here that the interests of the children are *de minimis.* Commitment to a mental institution is, of course, a "massive curtailment of liberty" for children as much as for adults. *Humphrey v. Cady,* 405 U.S. 504, 509 (1972). Moreover, "liberty" is an "interest of transcending value," which affects numerous other constitutional interests of extreme importance. *Speiser v. Randall,* 357 U.S. 513, 525 (1958). Most obvious, perhaps, is the deprivation of the "right of free association, a right closely allied to



freedom of speech and a right which, like free speech, lies at the foundation of a free society." *Shelton v. Tucker,* 364 U.S. 479, 486 (1960). "It is beyond debate that freedom to engage in association for the advancement of beliefs and ideas is an inseparable aspect of the 'liberty' assured by the Due Process Clause of the Fourteenth Amendment, which embraces freedom of speech." *N.A.A.C.P. v. Alabama ex rel. Patterson,* 357 U.S. 449, 460 (1958). *See DeJonge v. Oregon,* 299 U.S. 353, 364 (1937); *Wisconsin v. Yoder,* 406 U.S. 205 (1972). "Both oral and written communications are included within the First Amendment guarantee of freedom of speech." *Palmigiano v. Travisono,* 317 F.Supp. 776, 786 (D.R.I. 1970).

Commitment to a mental hospital also substantially affects the "right to privacy" of children, a right which this Court has sometimes referred to as "the right to be let alone." As this Court said in *Stanley v. Georgia,* 394 U.S. 557, 564 (1969):

> [A]lso fundamental is the right to be free except in very limited circumstances, from unwarranted governmental intrusion into one's privacy.
>
> "The makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness. They recognized the significance of man's spiritual nature, of his feelings and his intellect. They knew that only a part of the pain, pleasure and satisfactions of life are to be found in material things. They sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. *They conferred as against the Government, the right to be let alone—the most comprehensive of rights and the right most*

> *valued by civilized man." Olmstead v. U.S.,* 277 U.S. 438, 478, 48 S.Ct. 564, 572, 72 L.Ed. 944 (1928). (Emphasis added).

To similar effect are *Roe v. Wade,* 410 U.S. 179 (1973) and *Doe v. Bolton,* 410 U.S. 179 (1973); as this Court very recently has held, this right to privacy applies not only to adults but to children as well. *Planned Parenthood of Central Missouri v. Danforth,* 44 U.S.L.W. 5197, 5204 (U.S. July 1, 1976).

**B. The Due Process Clause of the Fourteenth Amendment Requires a Hearing Prior to Deprivation of Important Rights.**

While there have been many controversies over the exact meaning of due process of law, it has uniformly been acknowledged that due process at a minimum encompasses the right to be heard.

> For more than a century the central meaning of procedural due process has been clear; 'Parties whose rights are to be affected are entitled to be heard. . . .' *Baldwin v. Hale,* 1 Wall. 223, 233.
> *Fuentes v. Shevin,* 407 U.S. 67, 80 (1972).

Indeed, the opportunity to be heard has long been recognized as the *sine qua non* of due process, *Grannis v. Ordean,* 234 U.S. 385 (1914). It is not surprising, therefore, that in case after case this Court has held that the principles of due process of law compel the state to afford citizens some form of hearing before interference with personal or property rights of a substantial nature, *e.g., Goss v. Lopez,* 419 U.S. 565 (1975) (ten days of education); *Morrissey v. Brewer,* 408 U.S. 471 (1972) (parole revocation);



*Fuentes v. Shevin,* 407 U.S. 67 (1972) (property attachment); *Stanley v. Illinois,* 405 U.S. 645 (1972) (custody of one's children); *Bell v. Burson,* 402 U.S. 535 (1971) (revocation of driver's license); *Boddie v. Connecticut,* 401 U.S. 371 (1971) (access to divorce court); *Wisconsin v. Constantineau,* 400 U.S. 433 (1971) (public stigmatization as inebriate); *Goldberg v. Kelly,* 397 U.S. 254 (1970) (termination of welfare benefits); *Sniadich v. Family Finance Corporation,* 395 U.S. 337 (1969) (wage garnishment).

The constitutional requirement of a due process hearing has been found to encompass deprivations of both property and liberty interests [*compare, Sniadich v. Family Finance Corp., supra* (property), *with Wisconsin v. Constantineau, supra* (liberty)], irrespective of whether the interest threatened emanates from a constitutional or statutory source [*compare, Stanley v. Illinois, supra* (constitutional), *with Goldberg v. Kelly, supra* (statutory)].

In assessing whether or not the interest involved warrants due process protections, this Court has consistently looked at the nature of the right involved rather than the severity or gravity of the deprivation threatened. As was observed recently,

> The Court's view has been that as long as the property deprivation is not *de minimis,* its gravity is irrelevant to the question of whether account must be taken of the Due Process clause.
> *Goss v. Lopez,* 419 U.S. at 576.

Although the length and consequent severity of the deprivation have been found to be relevant factors

in determining the appropriate form of the hearing, they are not decisive as to the basic right to a due process hearing. *Fuentes v. Shevin,* 407 U.S. at 86. Moreover, where liberty interests, rather than property or economic interests are at stake, this Court has been even more stringent in applying the requirements of the Due Process Clause. *Stanley v. Illinois,* 405 U.S. 645, 651 (1972). Thus, where the liberty of an adult is threatened, this Court has imposed comprehensive due process protections, no matter how short the threatened confinement may be. *Argersinger v. Hamlin,* 407 U.S. 25 (1972). *See Ackies v. Purdy,* 322 F.Supp. 38 (S.D.Fla. 1970). Indeed, if appellees were adults whose liberty was being deprived in the utter absence of notice and an opportunity to be heard, there is not the slightest doubt that these procedures would violate their fundamental right to due process of law. As many cases have established, appellees' status as children cannot serve as a justification for such a deprivation. *In re Gault,* 387 U.S. 1 (1967); *Goss v. Lopez,* 419 U.S. 565 (1975).

Appellants have contended before this Court that the above cases are inapposite because the present action,

> is not concerned with the power of the state *vis-a-vis* the individual. Here there is a direct confrontation between the wishes of the child and his parent. Rather than state versus individual in this case it is child versus parent. (Brief for Appellants at 28-29).

This argument ignores the fact that it is the state itself which sanctions the incarceration of the chil-



dren here, authorizing by law the procedures which have been attacked. Hence, it is a state law that is under attack (Pa.Stat.Ann. tit. 50, §§4402-03), necessitating the three-judge court below (a jurisdictional decision to which appellants have taken no exception).

Furthermore, appellants' contention in the present case has been effectively undercut by this Court's very recent decision in *Planned Parenthood of Central Missouri v. Danforth,* 44 U.S.L.W. 5197 (U.S. July 1, 1976). In the *Planned Parenthood* case, as here, the parent-child relationship was the focus of attention. In that case, state law operated to effectuate the parental decision that the child could not have an abortion, thereby infringing the child's fundamental right to privacy; here state law operates to effectuate the parental decision to incarcerate the child, thereby infringing what may be an even more fundamental right, the right to liberty itself. Hence, it is the effect of a state law's impact upon the parent-child relationship which distinguishes the present case, as well as the *Planned Parenthood* case, from the purely private decision-making to which appellants would have this Court defer.

**IV. THE INTERESTS WHICH PENNSYLVANIA SEEKS TO VINDICATE DO NOT JUSTIFY MASSIVE CURTAILMENT OF APPELLEES' LIBERTY AND OTHER CONSTITUTIONALLY PROTECTED RIGHTS IN THE ABSENCE OF A JUDICIAL DETERMINATION THAT SUCH INTERVENTION IS APPROPRIATE AND NECESSARY.**

As *Amicus* has demonstrated in Part III, *supra,* the confinement of a child in a state mental hospital implicates numerous rights of the minor which have been found worthy of constitutional solicitude. These include the minor's right to liberty, privacy, freedom of association with relatives and friends, as well as the minor's right not to have his bodily integrity invaded by enforced administration of psychotropic medication,[17] or his reputation injured by being stigmatized as mentally ill.[18]

In short, enforced confinement in a state mental institution constitutes a severe and pervasive infringement upon interests and values deeply cherished under our constitutional scheme. According to the due proc-

[17]*Cf. Winters v. Miller,* 446 F.2d 65 (2d Cir. 1971), *cert. denied,* 404 U.S. 980 (1971).

[18]*Cf. Goss v. Lopez,* 419 U.S. 565 (1975). This interest in not being stigmatized is, in *Amicus'* view, especially significant in light of the incontrovertible evidence that: "[t]he suspicion and mistrust that have surrounded mental illness since the time treatment first began by exorcising demons will haunt and hinder the expatient when he returns to society." *Note, Civil Commitment of the Mentally Ill,* 14 U.C.L.A. L. Rev. 822, 831 (1967). Besides the social ostracism involved, stigma from a mental commitment has a ". . . devastating effect on [the expatient's] employability." Calif. Assembly Subcomm. on Mental Health Services, *The Dilemma of Mental Commitments in California,* 57-9 (1972). Hence, the mental patient's interests which are affected by his commitment to a state hospital may even transcend the deprivations he suffers while confined. As one court has remarked, "the very livelihood of the individual may be at stake." *In re Ballay,* 482 F.2d 648, 668 (D.C. Cir. 1973).



ess analysis which has been adopted by this Court, interests which cannot be characterized as *de minimus* must be safeguarded by some type of due process hearing. *See* Part III, *supra.* Moreover, it is self-evident that Pennsylvania's scheme of authorizing long-term confinement of minors in state mental institutions, without according them even a judicial hearing[19] does not satisfy due process requirements. Only through a judicial hearing procedure can minors who are not mentally disordered, or who may be better treated in a non-institutional setting, avoid the debilitating consequences of improper or inappropri-

[19]Subsequent to initiation of this lawsuit, Pennsylvania enacted regulations providing that minors 13 years of age or older who have been voluntarily committed to state mental institutions may initiate civil commitment proceedings under Pa.Stat.Ann. tit. 50, §4406 (1969). The regulations also provide that each such minor must receive written notification of his rights including his right to request representation by the Public Defender's office. Pa. Dep't of Public Welfare, Pa. Bull., Vol. 3, at 1840, Sept. 1, 1973. Brief for Appellants 9-15.

Belated enactment of these regulations does not moot this case. First, because what has been done can readily be undone, it is established law that voluntary abandonment of unlawful practices does not render a case moot. *Gray v. Sanders,* 372 U.S. 368, 376 (1963); *Anderson v. City of Albany,* 321 F.2d 649, 657 (5th Cir. 1963). Second, the regulations only apply to minors 13 years of age or older; they do not accord any due process protections whatsoever to minors under the age of 13.

Third, even as to minors over the age of 13, the regulations are clearly inadequate. Referral of a minor's case for commencement of civil commitment proceedings pursuant to §4406 does not guarantee when such a proceeding will actually be initiated or adjudicated. Neither the regulations nor §4406 contain any time requirements. Hence, minors who wish to contest their confinements may languish in mental hospitals for weeks or months awaiting the commencement of civil commitment proceedings, without even a probable cause determination as to the grounds for their detention. Finally, the regulations fail to guarantee the minor's right to present testimony and to cross-examine adverse witnesses, relief which was granted by the court below and which has historically been viewed as an essential component of a due process hearing.

ate commitments. Only such a procedure will ensure the uniformity and rationality of the commitment process as it is applied in each individual case. Finally, only a due process proceeding will maintain the appearance of fairness which, as this Court has remarked in a related context, may be as vital to the success of the treatment program as the treatment procedures themselves. *In re Gault,* 387 U.S. 1, 26 (1967).

Nevertheless, Pennsylvania advanced certain interests before the trial court which, it has claimed, justify the absence of judicial scrutiny of these confinements. These interests include: (1) assuring the mental health of children (*parens patriae*); (2) protecting the community; and (3) preserving the family unit and maintaining parental authority. *See Bartley v. Kremens,* 402 F.Supp. 1039, 1048 (E.D. Pa. 1975). It should be noted that the first two of these purported state interests apply as well to mental commitments of adults. Moreover, these identical state interests have been found constitutionally insufficient in a long line of federal and state court decisions mandating procedural safeguards in civil proceedings by which adults are committed to mental hospitals.[20] And all three state interests which appel-

[20]*See, e.g., Sarzen v. Gaughan,* 489 F.2d 1076 (1st Cir. 1973); *In re Ballay,* 482 F.2d 648 (D.C. Cir. 1973); *Suzuki v. Quisenberry,* 44 U.S.L.W. 2422 (D. Hawaii, Feb. 24, 1976); *Kendall v. True,* 391 F.Supp. 413 (W.D. Ky. 1975) (three-judge court); *Lynch v. Baxley,* 386 F.Supp. 378 (M.D. Ala. 1974) (three-judge court); *Bell v. Wayne County General Hospital at Eloise,* 384 F.Supp. 1085 (E.D. Mich. 1974) (three-judge court); *Welsch v. Likins,* 373 F.Supp. 487 (D. Minn. 1974); *Dixon v. Atty Gen'l of Penna.,* 325 F.Supp. 966 (M.D. Pa. 1971) (three-judge court);



lants have advanced below have, either explicitly or impliedly, been rejected as justifications for denying minors procedural rights in every reported decision examining the applicability of the due process clause to the placement of minors in mental institutions.[21]

In their brief before this Court, appellants seek to distinguish the adult commitment cases on the basis that adults—unlike minors—possess the right to refuse recommended medical treatment.[22] This distinction is specious, however, because it is the characteristic feature of any mental commitment proceeding that persons who are viewed as incompetent to make decisions for themselves are being committed against their wishes for enforced treatment. *See* Pa. Stat.Ann. tit. 50, §§4405, 4406. Incompetent adults and minors are in functionally analogous positions because they are both considered legally incompetent to either choose or reject treatment. Appellants' at-

*Lessard v. Schmidt,* 349 F.Supp. 1078 (E.D. Wis. 1972) (three-judge court), *vacated and remanded on other grounds,* 414 U.S. 473 (1974), *judgment reinstated,* 379 F.Supp. 1376 (E.D. Wis. 1974), *vacated and remanded on other grounds,* 95 S.Ct. 1943 (1975); *People v. Feagley,* 14 Cal.3d 338, 535 P.2d 373, 121 Cal. Rptr. 509 (1975); *Commonwealth ex rel. Finken v. Roop,* 234 Pa. Super. 155, 339 A.2d 764 (1975); *State ex rel. Hawks v. Lazaro,* 202 S.E.2d 109 (W.Va. 1974); *In re Fisher,* 39 Ohio St. 2d 71, 313 N.E.2d 851 (1974); *State ex rel. Farrell v. Stovall,* 59 Wis.2d 148, 207 N.W.2d 809 (1973); *Denton v. Commonwealth,* 383 S.W.2d 681 (Ky. 1964); *Ex parte Perry,* 137 N.J.Eq. 161, 43 A.2d 885 (1945).

[21]In addition to the present case are *Heryford v. Parker,* 396 F.2d 393 (10th Cir. 1968); *J.L. v. Parham,* 44 U.S.L.W. 2421 (M.D. Georgia Feb. 26, 1976) (three-judge court), *appeal filed,* 44 U.S.L.W. 3686 (U.S. June 1, 1976); *Kidd v. Schmidt,* 399 F.Supp. 301 (E.D.Wis. 1975) (three-judge court); *Saville v. Treadway,* 404 F.Supp. 430 (M.D. Tenn. 1974) (three-judge court); *In re Long,* 25 N.C. App. 702, 214 S.E.2d 626 (1975).

[22]Brief for Appellants at 50-51.

tempt to distinguish the adult commitment cases on the basis that mentally ill adults can reject treatment is therefore unconvincing; furthermore, appellants do not even attempt to distinguish the juvenile commitment cases cited in note 21, *supra*. The impressive array of state and federal court cases which have invalidated both adult and juvenile mental commitment schemes is indicative of the almost universal conclusion that due process procedures are required when a person is placed in a state mental hospital.

Although such precedent is not binding upon this Court, *Amicus* urges that it be accorded the deference traditionally reserved for decisions by judicial tribunals which enjoy a greater proximity than this Court to the political and social conditions in their jurisdictions.[23] *Amicus* believes that only with the greatest reluctance should this Court substitute its judgment for that of the court below and of other courts which have heard live testimony as to the manner in which commitment procedures actually operate under the harsh light of reality. With the hope of assisting in illuminating that reality, *Amicus* shall now consider, *seriatim*, each of the interests advanced by Pennsylvania in favor of its so-called voluntary commitment procedure for juveniles.

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[23] *Cf. United States v. Durham Lumber Co.*, 363 U.S. 522 (1960); *Propper v. Clark*, 337 U.S. 472, 486-87 (1949); *MacGregor v. Mutual Life Assurance Co.*, 315 U.S. 280, 281 (1942).



**A. Assuring the Mental Health of Children.**

**1. At Common Law the Parens Patriae Authority of the Sovereign Was not Exercised to Institutionalize the Mentally Ill.**

One of the state interests which, allegedly, is being promoted by the Pennsylvania voluntary commitment statutes is the promotion and protection of the mental health of Pennsylvania children. At common law the power of the King to act as guardian to promote the welfare of persons under legal disabilities was described by the term *parens patriae;* in modern days this royal prerogative of the King has passed to the states. *Hawaii v. Standard Oil Company,* 405 U.S. 251, 257 (1972). The power of the state to intervene in the affairs of children and incompetents is usually justified on the basis that both groups are incapable of exercising mature judgment. *See,* Note, *State Intrusion into Family Affairs: Justifications and Limitations,* 26 STAN. L. REV. 1383, 1392 n.52 (1974).

What is significant for present purposes is recognition that at common law *parens patriae* was not invoked to justify actual confinement of the mentally ill. A person found to be a lunatic was ordinarily committed to the custody of a friend who received an allowance with which to care for the unfortunate person. *See* 1 Blackstone, *Commentaries* 305 (Hammond ed. 1890). Thus, having developed at a time when public institutions for the mentally ill were virtually non-existent, the *parens patriae* doctrine which developed at common law cannot now be used to justify confinement of the mentally ill in institutions such as the mental hospitals we know today. *See Lessard v.*

*Schmidt,* note 20 *supra,* 349 F.Supp. at 1084-86. Moreover, in colonial America, parents were expected to care for their own mentally disabled offspring. S. Brakel and R. Rock, eds., *The Mentally Disabled and the Law* 4 (1971). Hence, at common law and during the early stages of the history of this country, the authority of the sovereign to intervene *parens patriae* was not used to justify the more recent American innovation of using the Latin phrase to justify total, and in some cases permanent, loss of liberty. *See Lessard v. Schmidt, supra* at 1085; N. Kittrie, *The Right to be Different: Deviance and Enforced Therapy* 66 (1971).

In the juvenile sphere this Court has similarly traced the background of the state's purported power to deny minors procedural rights available to adults. This Court's conclusion with regard to the state's *parens patriae* authority over juveniles parallels the conclusions which have been reached with regard to the historical basis for the state's power over incompetents:

> The constitutional and theoretical basis for this peculiar system is—to say the least—debatable. *In re Gault,* 387 U.S. 1, 17 (1967).

**2. This Court's Analysis in In re Gault, Disposes of Appellants' Parens Patriae Argument.**

In recent years this Court has consistently rejected "civil labels," "good intentions," or *"parens patriae"* as justifications for denying criminal due process safeguards to minors in juvenile court. *Breed v. Jones,* 421 U.S. 519, 530 n.12 (1975); *In re Winship,* 397



U.S. 358, 365-66 (1969); *In re Gault,* 387 U.S. 1, 18, 19 (1967). Instead, this Court has measured the need for due process procedures against what it has termed the "reality" of institutional confinement. *In re Gault, supra,* 387 U.S. at 26-31. In *Gault,* this "reality" was described by Justice Fortas as follows:

> The boy is committed to an institution where he may be restrained of liberty for years. It is of no constitutional consequence—and of limited practical meaning—that the institution to which he is committed is called an Industrial School. The fact of the matter is that, however euphemistic the title, a 'receiving home' or 'industrial school' for juveniles is an institution of confinement in which the child is incarcerated for a greater or lesser time. His world becomes a 'building with whitewashed walls, regimented routine and institutional hours . . . .' Instead of mother and father and sisters and brothers and friends and classmates, his world is peopled by guards, custodians, state employees, and 'delinquents' confined with him for anything from waywardness to rape and homicide. *Id.* at 27.

The institutional surroundings; the absence of the minor's most cherished companions; compelled association with persons who have committed deviant and anti-social conduct; the pervasive deprivation of individual liberty: it is these realities which impelled this Court to require extensive due process safeguards in *Gault.* Even the slightest familiarity with state mental institutions elicits recognition that this Court's description of training school life in *Gault* is equally

applicable to our state mental institutions,[24] and therefore, that the due process protections against unwarranted or inappropriate commitments mandated by this Court in *Gault* are essential to safeguard the integrity of the mental hospital placement process.

The lack of adequate treatment resources in most of our state mental institutions is so widespread that in *Jackson v. Indiana,* 406 U.S. 715 (1972), this Court recognized that the rationale for most pre-trial commitments of "incompetent" criminal defendants is dubious, ". . . given the state of most of our mental institutions." *Id.* at 734-35. In a case before a three-judge federal district court, Pennsylvania conceded that only three percent of the inhabitants of one of its state mental hospitals received any therapeutic-psychiatric treatment whatsoever. *Dixon v. Attorney Gen'l of Penna.,* 325 F.Supp. 966, 969 (M.D. Pa. 1971). Two research psychologists who arranged to be admitted to Pennsylvania's largest mental institution, the Philadelphia State Hospital, reported that life inside the hospital was characterized by an overwhelming sense of boredom and betrayal. Because of a shortage of staff—only three attendants to every eighty-five patients—the patients learned that they

[24]"Recent studies—notably those of Drs. Erving Goffman, William Caudill, and Ivan Belknap, based on prolonged ward observation—attest to the continuance of the stripping of the patient, loss of his individuality and dignity, depersonalization, and demoralization. The chronically acute shortage of physicians in most wards makes the term 'psychotherapy' a hideous mockery for most patients. In most public mental hospitals, the average ward patient comes into person-to-person contact with a physician about fifteen minutes every month—not a day or a week, but a month." *Testimony of Dr. Albert Deutsch Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary,* pt. 1, 40, 43-44, 87th Cong., 1st Sess. (1961).



could earn little favors, such as coffee, cigarettes, and access to the sunlit dayroom, if they "learn to be sick" and cooperate with the staff. *New York Times,* January 14, 1969 at 10, col. 3.

As of June 30, 1966 there were only 180 full-time psychiatrists employed by Pennsylvania's eighteen state mental hospitals for an average daily census of 34,920 patients, resulting in a physician-patient ratio of 1 to 194. Note, *Hospitalization of the Mentally Disabled in Pennsylvania: The Mental Health and Mental Retardation Act of 1966,* 71 Dick. L. Rev. 300, 334-35 n.174 (1967). The figure of 180 psychiatrists includes 31 superintendents and assistant superintendents preoccupied with administrative functions as well as 43 psychiatric residents who principally train rather than care for patients. *Id.* Hence, the actual ratio of practicing full-time psychiatrists to patients in Pennsylvania in 1966 was one psychiatrist to 320 patients.

The snake-pit conditions of most of our mental hospitals is so widespread as to have received almost universal recognition.[25] These conclusions are sup-

[25]"[E]ighty percent of mental institutions are purely custodial, providing no treatment of any significance even to their law abiding patients. . . . A good portion of the remaining twenty percent provide adequate treatment only for well-paying private patients." Schmideberg, *The Promise of Psychiatry: Hopes and Disillusionment,* 57 Nw.U.L. Rev. 19, 22 (1962). In a very recent book a distinguished physician concludes with considerable dismay: ". . . the state psychiatric facilities can, at best, be described as medieval horrors and an offense to our civilization and a blot on psychiatry." Peskze, *Involuntary Treatment of the Mentally Ill* 67 (1975). "State mental hospitals suffer, perhaps, from more maladies than their inhabitants." Robitscher, *The Right to Psychiatric Treatment: A Social-Legal Approach to the Plight of the State Hospital Patient,* 18 Vill.L. Rev. 10, 11 (1972).

ported by numerous studies which have found that varying methods of in-hospital treatment of psychiatric patients have not differentially affected discharged patients' functioning in the community as measured by recidivism, post-hospital employment, or any other suitable measure of behavior.[26] Dr. Alan Stone of the Harvard Law School, who is perhaps the leading scholar in the country on the relationship between mental health and the law, has echoed these exact sentiments with regard to in-hospital psychiatric treatment of children. Stone, *Mental Health and Law: A System in Transition,* National Institute of Mental Health (DHEW Pub.No. (ADM) 75-176, 1975).[27]

In *In re Gault, supra,* this Court reiterated its concern—expressed earlier in *Kent v. United States,* 383 U.S. 541, 556 (1966)—that children charged with the commission of delinquent conduct receive, "the worst of both worlds"; they get "neither the protections accorded to adults nor the solicitous care and regenerative treatment postulated for children." *In re Gault, supra,* 387 U.S. at 18 n.23. *Amicus* believes

[26]The applicable literature is reviewed extensively in Schwitzgebel, *The Right to Effective Mental Treatment,* 62 Cal.L. Rev. 936 (1974). *See* Anthony, Buell, Sharott, and Althoff, *Efficacy of Psychiatric Rehabilitation,* 78 Psychological Bulletin 447 (1972).

[27]Professor Stone attributes the lack of available effective treatment for children to the following factors: "(a) Inpatient psychiatric facilities for children with rare exception have been horrendous. (b) Whatever the value of traditional diagnostic criteria may be they are not readily applicable to children, except in the case of profound illness. (c) Psychotherapeutic methods that do exist are geared to the intact family, and that is rarely the target group of the juvenile courts. (d) Finally, as Justine Wise Polier points out, the dollar and resource cost of the medical model approach is totally unrealistic." *Id.* at 146.



that the overwhelming weight of available evidence demonstrates that minors confined to state mental institutions are similarly: (a) subject to severe and massive deprivations of liberty; (b) often confined under conditions which can only be considered debasing and dehumanizing; and (c) receiving mere custodial care, rarely benefiting from any meaningful therapeutic treatment.

It is *Amicus'* position that as in *Gault, supra,* the institutional reality which greets minors who are processed through Pennsylvania's "voluntary admission and commitment" system (Pa.Stat.Ann. tit. 50, §§4402-03) must be considered by this Court in determining whether due process protections must be provided. And because at the very least, there is considerable cause to question whether the legislative promise of "treatment" will be fulfilled,[28] *Amicus* believes that rigorous due process procedures are necessary to safeguard the rights of minors who may not require institutionalization. As in *Gault, supra,* these due process protections are especially appropriate because the minor plaintiffs in the present case: (a) are being processed through a special system lacking the procedures available to similarly situated adults; (b) are given no choice in the decision to undergo treatment;[29] (c) are being confined in order to forcibly

[28]Pa.Stat.Ann. tit. 50, §§4402 and 4403 authorize confinement of minors in state mental hospitals by their parents solely "for examination, treatment and care."

[29]It is ironic that under Pa.Stat.Ann. tit. 50, §§4402 and 4403, the wishes of even mature and competent minors are immaterial to the treatment decision. Even minors who, in the hospital's view, clearly require treatment and who desire it may not be admitted for hospitalization under these statutes if their parents or guardians refuse to consent to their treatment.

provide them with treatment; (d) may be confined indefinitely until they attain their age of majority; and (e) will be released only when a discretionary determination has been reached that they are sufficiently "cured" or "rehabilitated" to warrant their return to society.

Appellants present three principal arguments as to why, in their view, the *Gault* due process analysis is inappropriate. *First,* they note that in *Gault* this Court confined its consideration to delinquency proceedings which are basically quasi-criminal in nature.[30] This distinction, if given determinative weight, paints *Gault* with too narrow a brush. As discussed earlier, this Court in *Gault* was concerned with far more than the quasi-criminal aspects of delinquency proceedings. If this Court's decision had turned solely upon the quasi-criminal nature of delinquency proceedings, there would have been no reason to focus at such length upon the realities and limitations of institutional treatment. Hence, this Court has not limited the application of the Due Process Clause to criminal or quasi-criminal proceedings. *See, e.g., Goss v. Lopez,* 419 U.S. 565 (1975); *Stanley v. Illinois,* 405 U.S. 645 (1972); *Goldberg v. Kelly,* 397 U.S. 254 (1970).

Appellants would convince this Court that the absence here of a legitimate police power interest in quasi-criminal conduct justifies a relaxation of due process rigor. Of course, the converse is true. Since the Pennsylvania voluntary commitment scheme is premised solely upon the state's interest in promoting

[30]Brief for Appellants at 37-40.



the health of its citizens, even greater vigilance is required to assure that persons are not being improperly denied their liberty.[31] The absence of any requirement that commitment be based on specific conduct, combined with the absence of clear-cut statutory criteria for commitment, suggests the abuses to which such a vague statute may be subject. Minors who have committed no anti-social acts, and who do not wish to be confined in state mental institutions, surely have as much right as the alleged delinquents in *Gault* to demonstrate that the state has not satisfied the criteria it has established for their institutionalization and treatment. As this Court stated in *Minnesota v. Probate Court,* 309 U.S. 270 (1940):

> We fully recognize the danger of a deprivation of due process in proceedings dealing with persons charged with insanity or, as here, with a psychopathic personality as defined in the statute, and the special importance of maintaining the basic interests of liberty in a class of cases where the law though 'fair on its face and impartial in appearance' may be open to serious abuses in administration and courts may be imposed upon if the substantial rights of the persons charged are not adequately safeguarded at every stage of the proceedings. 309 U.S. at 276-77.

*Second,* appellant notes the uncertainty of psychiatric diagnosis and suggests that, unlike an adjudication of guilt or innocence, mental commitment

[31]"Experience should teach us to be most on our guard to protect liberty when the Government's purposes are beneficent." *Olmstead v. United States,* 277 U.S. 438, 479 (1928) (Brandeis, J., dissenting).

proceedings serve little purpose other than to confirm previously made psychiatric diagnoses.[32] If this were true, it is curious that appellants also refer to studies[33] which show that requiring court review of medical diagnoses generally results in decreased institutionalization.

Of course, a mental commitment proceeding differs markedly from a criminal or delinquency trial in terms of the nature of the fact-finding adjudication which the jury or judge is required to make. However, this Court has found such a separate proceeding focusing upon dangerousness, habituality, or mental illness to be fully within the ambit of due process protection. *Specht v. Patterson,* 386 U.S. 605 (1967). Under Pa. Stat. Ann. tit. 50, §§4102, 4402, and 4403, a determination must be made that a minor who is to be voluntarily committed suffers from a "mental disability" and is in need of care, observation, or treatment. These statutory criteria are clearly susceptible to judicial scrutiny; and it appears quite probable that should such an issue be raised, Pennsylvania courts would also have to consider whether the mere satisfaction of such a standard warrants long-term confinement of mentally ill children.[34] It is also somewhat ironic that appellants are arguing that an adversary proceeding

[32]Brief for Appellants at 42-43.

[33]*Id.* at 44 and 37.

[34]This Court has suggested that there are due process limitations upon the state's power to confine involuntarily those persons who are mentally ill. *Jackson v. Indiana,* 406 U.S. 715, 737 (1972); *Cf. Humphrey v. Cady,* 405 U.S. 504, 509 (1972). Recently, in *O'Connor v. Donaldson,* 422 U.S. 563 (1975), this Court found in the due process clause substantive limitations upon the state's power to confine involuntarily mentally ill persons who are dangerous to no one and who can live safely in freedom. The approach



serves no useful function when, concomitantly, they offer their own belatedly created adversary mechanism for minors thirteen years of age or older[35] as a model of due process. The decision of appellants to accord adversary hearings to at least some minors vitiates their argument that such a process is nugatory.

Finally, appellants contend that *Gault* is inapplicable because here minors are being placed in a hospital by parents which, according to appellants, is qualitatively different from the court-ordered adjudication and commitment in *Gault.*[36] Appellants ignore in this part of their argument the fact that the Due Process Clause does circumscribe even a parent's discretion over his children in some areas.[37] But if appellants are basically claiming that there is no state action, it cannot be overlooked that appellee minors were confined in *state* mental hospitals pursuant to procedures and authority vested in those institutions by *state* statutes. And to the extent that appellees' parents are indigent, the cost of paying for their treatment is, presumably, borne by *state* taxpayers. Pennsylvania can no more readily escape responsibility for its own statutory scheme than could Arizona have circum-

taken by this Court in *Donaldson* suggests that even if, *arguendo,* Pennsylvania had declined to enact statutory criteria for "voluntary" commitment of juveniles, it would nevertheless be the function of the courts to determine if institutionalization in any given case was sufficiently related to a permissible state purpose to satisfy due process.

[35]Pa. Dep't of Public Welfare, Pa. Bull., Vol. 3 at 1840, Sept. 1, 1973.

[36]Brief for Appellants at 34-36.

[37]*Amicus* addresses this argument in Part IVC, *infra.*

vented *Gault* by legislating that parents could place minors directly in state training schools without the filing of juvenile court petitions.

**B. Protecting Society.**

A second permissible purpose which the state may seek to effectuate in institutionalizing its mentally ill minors is protection of the community. However, appellants have not seriously argued in this Court that the statutes under consideration are intended to effectuate this permissible state function. Nor would such an argument be tenable. Pa. Stat. Ann. tit. 50, §§4402 and 4403 authorize confinement of a minor in a state mental hospital upon application by his parent, guardian, or an individual standing *in loco parentis,* if it is determined that the minor is in "need of care or observation." Since the institutionalization of minors who pose no legitimate threat to the persons or property of others is sanctioned, it is evident that the scope of statutory authority exceeds the state's police power. In addition, the mere existence of a legitimate police power motive, even if promoted by the statutes, would not itself justify the absence of procedural safeguards. *Breed v. Jones,* 421 U.S. 519 (1975); *Jackson v. Indiana,* 406 U.S. 715 (1972); *In re Gault, supra; Heryford v. Parker,* 396 F.2d 393 (10th Cir. 1968); *People v. Feagley,* 14 Cal. 3d 338, 535 P.2d 373, 121 Cal. Rptr. 509 (1975).

**C. Preserving the Family and Maintaining Parental Authority.**

The principal interests which appellants assert in support of Pennsylvania's voluntary commitment



scheme are the preservation of the family unit and, especially, the maintenance of parental authority. Appellants note that the decision to provide a child with medical care has traditionally been considered the prerogative of the child's parents. Appellants equate long-term institutionalization of a child in a mental hospital with, for example, elective surgery; and they conclude that both procedures should be treated by the law in a similar fashion. In support of their contention that the state may intervene in the affairs of the family only in the most limited circumstances, appellants cite *Wisconsin v. Yoder,* 406 U.S. 205 (1972); *Pierce v. Society of Sisters,* 268 U.S. 510 (1925); and *Meyer v. Nebraska,* 262 U.S. 390 (1923).

At common law children were treated generally as the property of their parents—exercising few independent rights. A parent was considered the general guardian of the child's person even though the parent could not—except in limited, well-defined circumstances—dispose of the child's property. *See Hoyt v. Hammekin,* 55 U.S. 346 (1852); *Maryland Casualty Co. v. Lawson,* 110 F.2d 269 (5th Cir. 1940). It is sobering to recall that only one hundred years ago the American Society for Prevention of Cruelty to Animals was empowered by the courts to act in a case of cruelty to a child on the basis that a child is an animal. Mitchell, *The Child and Experimental Medicine,* 1 Brit. Med. J. 721, 722 (1964).

In recent years, however, courts have increasingly recognized the constitutional rights of children. *See, e.g., Goss v. Lopez,* 419 U.S. 565 (1975); *Tinker v.*

*Des Moines Independent School District,* 393 U.S. 503 (1969); *In re Gault,* 387 U.S. 1 (1967). Although these cases do not involve a direct conflict between the rights of children and the authority of their parents, these decisions treated children as independent entities exercising rights derived—not from their parents—but rather from their status as persons under the Constitution. In *Gault,* for example, this Court rejected the juvenile court rationale that a parent may be relied upon to protect the interests of the child. *In re Gault, supra,* 387 U.S. at 35.

Prior to its decision in *Planned Parenthood of Missouri v. Danforth,* 44 U.S.L.W. 5197 (U.S. July 1, 1976), this Court had never decided a case squarely presenting a direct conflict between children's rights and parental authority. Hence, the prior decisions of this Court which are relied upon by appellants, *Pierce v. Society of Sisters, Meyer v. Nebraska,* and *Wisconsin v. Yoder, supra,* are inapposite because each involved solely a conflict between the power of the state and the authority of the parent. Referring to this line of authority, one court has correctly noted:

> . . . those cases which have considered parental control of children have involved conflicts between parents and the state wherein the courts have considered intrusions by the state into the area of parental values—particularly religious values. Cases which have upheld parental control have not involved a situation where the parent and child differ and the state is imposing the parents' views on the minor. *Foe v. Vanderhoof,* 389 F.Supp. 947, 956 (D. Col. 1975); *see Baird v. Bellotti,* 393 F. Supp. 847, 856-57 (D. Mass. 1975), *vacated and remanded,* 44 U.S.L.W. 5221 (U.S. July 1, 1976).[38]



Although the conflict of interest between parent and child was not raised explicitly in any of these prior cases, it is certainly possible to read each of the decisions as vindicating not only the authority of the parent, but additionally the rights of the child. Hence, *Meyer v. Nebraska,* 262 U.S. 390 (1923), had at least the practical effect of enhancing the opportunities for minors who had not graduated from the eighth grade to study modern foreign languages. *Pierce v. Society of Sisters,* 268 U.S. 510 (1925), of course, vindicated a parent's right to send her children to private school; but this Court also made it quite clear that it was protecting as well the right of children not to be forced to receive a "standardized" education. *Id.* at 535. In *Wisconsin v. Yoder,* 406 U.S. 205 (1972), this Court assumed, without deciding, that both Amish children and their parents preferred that the children receive a non-public education. And in *Prince v. Massachusetts,* 321 U.S. 158 (1944), this Court emphasized that society's concern for the welfare of its children

> . . . is no mere corporate concern of official authority. It is the interest of youth itself. 321 U.S. at 165.

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[38] In *Foe v. Vanderhoof, supra,* the court was referring in its decision specifically to *Pierce v. Society of Sisters, Meyer v. Nebraska,* and *Prince v. Massachusetts, supra.* Although not referred to explicitly, the district court's comment also applies to *Wisconsin v. Yoder, supra,* where this Court qualified its holding by stating: "Our holding in no way determines the proper resolution of possible competing interests of parents, children, and the State in an appropriate state court proceeding." 406 U.S. at 231.

Hence, although these decisions did not expressly resolve conflicts between children's rights and parental authority, this Court did recognize that the child's welfare is an independent interest warranting solicitude and protection.

In *Planned Parenthood of Central Missouri v. Danforth,* 44 U.S.L.W. 5197 (U.S. July 1, 1976), this Court, for the first time, balanced the constitutional rights of children against the competing interests of their parents. This Court held that whatever interests a parent may have in the termination of his minor daughter's pregnancy was not more worthy of constitutional protection than the minor's right to privacy. Accordingly, this Court invalidated the Missouri statute which had conditioned the minor's right to an abortion upon parental consent. 44 U.S.L.W. at 5204.

*Planned Parenthood, supra,* is instructive in several significant ways. First, this Court recognized explicitly that minors possess constitutional rights independent of their parents, and that these rights are entitled to be safeguarded even against competing claims by the minors' parents. In the present case, these rights include, not only privacy, but also the right of the minor not to be denied liberty without due process of law—the constitutional safeguard which above all others distinguishes our system of orderly justice. *See Grannis v. Ordean,* 234 U.S. 385 (1914).

Second, in *Planned Parenthood,* this Court rejected the Attorney General's argument that requiring parental consent would be likely to further the state's interest in promoting family unity. 44 U.S.L.W. at 5204. Likewise, it must be seriously doubted whether vesting authority in parents to place their children in mental hospitals without a judicial hearing is likely to promote family unity or harmony. The child who has no role in the commitment decision, is, as this Court has elsewhere recognized, unlikely to have confidence in the person or the system which refuses to accord him legitimate participation in decisions vitally affecting his interests. *See, e.g., Breed v. Jones,* 421 U.S. 519 (1975).



Third, this Court held that the constitutional deficiency in the Missouri statute rested in its imposition of an absolute limitation on the minor's right to obtain an abortion. As explained by Justice Stewart in his concurring opinion, the statute failed to provide for "prompt" judicial resolution of disagreements between parents and minors. It also failed to provide for judicial determinations as to the minor's ability to give informed consent without parental concurrence, or as to whether abortion would, in any event, be in the minor's best interests. 44 U.S.L.W. at 5208-09.

The Pennsylvania statutes under challenge in the present case suffer from similar deficiences. They create an absolute limitation on the minor's right not to be forcibly placed in a mental hospital. Under Pa. Stat. Ann. tit. 50 §§4402 and 4403, the minor's wishes, maturity, and best interests are immaterial to the parents' placement decision. Although Pennsylvania has

adopted regulations[39] affording minors over the age of thirteen the right to request that a hearing be commenced on their behalf, the Pennsylvania regulations (even as to minors above the age of 13) fail to ameliorate the basic defects held fatal to the Missouri statute in *Planned Parenthood, supra.* As discussed more extensively at pp. 67-68, *infra,* the regulations fail to require that a hearing will be conducted within any specific period of time, fail to provide for mandatory appointment of counsel, and fail to consider the minor's ability to make an informed and mature decision as to whether confinement and treatment in a mental institution would be in the minor's best interests. The Pennsylvania regulations fail to extend the due process right to a *prompt* judicial hearing even to mature and competent minors. By rendering the due process right of such minors wholly subservient to the decisions of others, without requiring either appointment of counsel or judicial scrutiny within a reasonable period of time, the Pennsylvania regulations are wholly inconsistent with the thrust of *Planned Parenthood, supra.*

Finally, it is essential to recognize that the dissenting opinions in *Planned Parenthood, supra,* rested upon a factual foundation inapplicable in the present case. In dissent, both Justices White and Stevens stressed the important function of parental counselling in ensuring that the minor's decision to terminate her pregnancy would be reasoned and well-considered. 44

[39]Pa. Dep't of Public Welfare, Pa. Bull., Vol. 3, at 1840, Sept. 1, 1973.



U.S.L.W. at 5210. (separate opinion of White, J.); 44 U.S.L.W. at 5212-13 (separate opinion of Stevens, J.). The vital significance of the parent's role as counselor was supported by evidence in *Planned Parenthood, supra,*[40] as well as in *Bellotti v. Baird,* 44 U.S.L.W. 5221 (U.S. July 1, 1976), that physicians and other persons who work at abortion clinics are unable to adequately perform this counselling function.

No similar state purpose is promoted by the Pennsylvania scheme. First, it is questionable whether vesting commitment powers in persons other than the child, without recognizing the child's right to participate in the placement decision, would be likely to promote interchange between parent and child. Unlike the decision to terminate pregnancy, which is normally made at least initially by the minor, the decision to place a minor in a mental hospital can, and under Pennsylvania law frequently would, be made by a parent without prior consultation with his child. The purported mental illness of the minor would also be likely to discourage a parent from seeking the child's concurrence in the parent's commitment decision.

Second, assuming that some form of counselling would be desirable, a parent is not necessarily the appropriate person to perform that function. As more fully discussed in Part IV C 3 and 4, *infra,* many parents are too intensely involved, either in a conflict of interest or in the family's emotional difficulties to serve as dispassionate advisors to their children. To

[40]44 U.S.L.W. 5197, 5209 n.2.

the extent that the child's emotional problems are representative of broader familial dysfunction, the inappropriateness of the parent serving as counselor is self-evident.

Finally, under the decision of the court below, the minor would have available to him an attorney who could advise him as to both the legality and appropriateness of treatment in a mental hospital. This is a traditional role performed by the mental health bar, and would do much to ensure that the minor's decision to concur in, or to oppose, a placement in a mental hospital would be based upon the advice of a mature and neutral adult.

*Amicus* does not question the general authority of parents as the persons best suited and primarily responsible for the rearing of their children. Indeed, parental authority, while not absolute *(Prince v. Massachusetts, supra)*, is the cornerstone of our family structure. However, increasing recognition that children also have rights under our Constitution, even when those rights conflict with competing rights of their parents, as in *Planned Parenthood, supra,* requires a searching and sensitive examination of the interests and considerations pertinent to all parties.

*Amicus* believes that there are a number of significant factors which must be considered in determining when parental authority should be subject to judicial scrutiny. These include: (a) the nature and severity of the deprivation of the child's interests, and whether these interests are subject to constitutional protection; (b) the potential for harm to the



child; (c) whether the parents' decision has the effect of preserving, or disrupting, the family structure; (d) the potential for conflict of interest between parent and child; (e) the legitimacy in each situation of the normal presumption that a parent will act in his child's best interests; (f) the existence of non-judicial alternatives to safeguard the interests of the child; and (g) the child's capacity to make competent and reasoned determination as to what is in his own best interest. When these factors are closely scrutinized, the necessity for judicial review of the parent's decision to seek commitment of his child is evident.

**1. Minors Who Are Inappropriately Confined in Mental Hospitals Are Subject to Severe Emotional and Psychic Harm.**

As previously discussed,[41] the decision to confine a child in a state mental hospital implicates a number of the child's constitutionally protected rights. Children who are inappropriately confined in mental institutions are especially subject to severe emotional and psychic harm. *See Mathews v. Hardy,* 420 F.2d 607, 611 (D.C. Cir.), *cert. denied,* 397 U.S. 1010 (1970); *cf. In re Ballay,* 482 F.2d 648, 667 (D.C. Cir. 1973). Providing judicial review of commitments would serve to ensure that only those minors who require hospital treatment will be institutionalized.

**2. The Decision to Commit a Child to a State Hospital Necessarily Constitutes a Disruption of Family Harmony.**

When a parent seeks to place his child outside of the family structure, he cedes some of his normal priv-

[41] pp. 19-22, *supra.*

ilege to be free from state scrutiny. The state's ordinary reluctance to intervene in family affairs reflects an appreciation for the virtues in family autonomy. But when a parent removes a child from his family, and places him in a state institution, the sacrosanctity of family autonomy has already been breached by parental decision. There is no more reason to avoid judicial review of such a decision than there is of a parent's determination to place his child in a state training school, a local detention facility, or a juvenile camp. See *In re Gault, supra.*

Moreover, *Amicus* believes there is a qualitative difference between a parent's decision to seek medical treatment for his child, and his determination to commit his child to a mental institution. Medical care does not necessarily require hospitalization; but even if hospitalization is deemed necessary, institutionalization is ancillary to treatment. Mental commitments, on the other hand, are by definition custodial confinements. By their very nature such commitments are of indefinite duration and, frequently, are extensive in length. Given the absence of adequate treatment resources in many state hospitals,[42] the custodial confinement may itself become the treatment. *See* Braginsky, Braginsky & Ring, *Methods of Madness: The Mental Hospital as a Last Resort* 179-80 (1969). And, to quote Justice Frankfurter, as a result of ". . . the uncertainty of diagnosis in this field and the tentativeness of the professional judgment." [*Greenwood v. United States,* 350 U.S. 366, 375 (1956)], the psychi-

[42]*See* pp. 34-36, *supra.*



atrist's decision as to when a patient should be released from a mental hospital would appear far less subject to a set of commonly accepted medical norms than, for example, the decision as to when a hospital shall discharge a patient following a hernia operation.[43] Finally, as previously noted,[44] the stigma of having been found "mentally disordered" transcends any opprobrium which might attach to hospitalization for non-therapeutic, medical reasons.

Notwithstanding these differences between treatment in medical hospitals and mental institutions, many courts have circumscribed the parent's right to make *medical* decisions for his child when the potential consequences to the child are sufficiently grave and/or there is reason to believe that the interests of the child are not being fully considered by the parent. Hence, it is now commonly accepted that where it is necessary to save the child's life, a court may authorize blood transfusions for a child, even over the First Amendment objections of parents who are Jehovah's Witnesses. *See, e.g., State v. Perricone,* 37 N.J. 463, 181 A.2d 751 (1962), *cert. denied,* 371 U.S.

[43]Since Pennsylvania law does not require any initial determination as to dangerousness to self or others in order to commit a juvenile to a mental hospital under Pa. Stat. Ann. tit. 50, §§4402 and 4403, the hospital's decision to discharge a patient rests almost entirely upon a discretionary determination that the patient has been "sufficiently" cured. It is difficult to conceive of a standard which would vary more from hospital to hospital and physician to physician. See *Commonwealth ex rel. Finken v. Roop,* 234 Pa. Super. 155, 339 A.2d 764 (1975), finding the statutory commitment standard under Pa. Stat. Ann. tit. 50, §§4406, "in need of care" unconstitutionally vague: "Once a finding of mental illness is made, it would be impossible not to find that the individual is in need of care." 234 Pa. Super. at ....., 339 A.2d at 778.

[44]Note ***, *supra.*

890 (1962); *People v. Labrenz,* 411 Ill. 618, 104 N.E.2d 769 (Schaefer, J.), *cert. denied,* 344 U.S. 824 (1952). Contrary to appellants' assertions,[45] courts will intervene in behalf of children even where there is no threat to the life of the child. *In re Sampson,* 29 N.Y.2d 900, 278 N.E.2d 918, 328 N.Y.S.2d 686 (1972).[46] And although the Supreme Court of Pennsylvania has ruled that the state does not have a sufficient interest to overrule a parent's religious objection to surgery when the child's life is not immediately imperiled, the court refused to uphold the parent's authority as against the wishes of their sixteen-year-old son. Instead, the court remanded for consideration of the boy's desires. *In re Green,* 448 Pa. 338, 292 A.2d 387 (1972).

**3. The Ordinary Presumption That Parents Are Acting in Their Child's Best Interests Is Often Questionable When Parents Seek to Transfer the Responsibility of Caring for Their Children to the State.**

Most medical decisions concerning children are appropriately left to the discretion of parents; but as we have observed, courts are not unwilling to intervene where the consequences to the child appear sufficiently grave—especially when there is reason to believe that the child's wishes and interests, as distinguished from his parents', are not receiving ample consideration. Perhaps no other decision concerning

[45]Brief for Appellants at 32.

[46]Although in deciding *In re Sampson,* the New York Court of Appeals sought to distinguish its prior decision in *In re Seiferth,* 309 N.Y. 80, 127 N.E. 2d 820 (1955), relied upon by appellants, we submit that the effect of *In re Sampson,* concurred in by Chief Judge Fuld who had dissented in *Seiferth,* was to overrule the court's earlier case.



the health of children warrants independent scrutiny as clearly as the decision to commit a child to a mental institution.

Where familial dysfunction occurs, it makes little sense to vest commitment power in one of the family members—even a parent. Numerous studies and articles report that problem behavior in children is often symptomatic of ineffectual interpersonal relationships among family members.[47] A response of some parents to severe family stress is to scapegoat their children, in some instances even institutionalizing them so that the parents will not have to deal directly with these problems.[48] As for parents of mentally retarded young-

[47]*See, e.g.,* Spiegel, *The Resolution of Role Conflict Within the Family,* in *A Modern Introduction to the Family,* 361-81 (N. Bell & E. Vogel eds. 1960); Vogel & Bell, *The Emotionally Disturbed Child as the Family Scapegoat,* in *A Modern Introduction to the Family, supra,* at 382-97; Carek, Hendrickson, and Holmes, *Delinquency Addiction in Parents,* 4 *Arch. Gen. Psychiatry,* 357-62 (1961); Marrow, *Flexibility in Therapeutic Work with Parents and Children,* 38 *Bulletin of the Menninger Clinic,* No. 2, at 129 (March 1974); Kreisman and Jay, *Family Response to the Mental Illness of a Relative: A Review of the Literature,* 10 Schizophrenia Bull. 34 (1974).

[48]One study reports that, from the parents' standpoint, scapegoating their children is not without utility. "For the parents, scapegoating served as a personality-stabilizing process. While the parents of these children did have serious internal conflicts, the projection of these difficulties onto the children served to minimize and control them. . . . From the point of view of the family, the primary function of scapegoating is that it permits the family to maintain its solidarity. . . . In all the disturbed families, very serious dissatisfactions between spouses came to light during the course of therapy . . . ." Vogel and Bell, *The Emotionally Disturbed Child as the Family Scapegoat,* in *A Modern Introduction to the Family,* 394-95 (N. Bell & E. Vogel eds. 1960).

*See* Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions,* 62 Cal. L. Rev. 840, 859-62 (1974); T. Scheff, *Being Mentally Ill: A Sociological Theory* 171 (1966) (noting a Philadelphia study which found that in 25 percent of the complaints of mental illness, it was the complainant, rather than

sters, one commentator has enumerated some of the factors motivating such parents to seek institutionalization of their children, including the interests of other children in the family, the mental and physical frustrations of the parents, economic strain resulting from caring for the children at home, hostility resulting from the burden of caring for the children, and the parent's success-oriented expectations for their children. Murdock, *Civil Rights of the Mentally Retarded: Some Critical Issues,* 48 *Notre Dame L. Rev.* 133, 139-43 (1972). These considerations dramatize very real problems which confront parents of retarded or severely disturbed youngsters. The legal system, however, should not exalt the parents' difficulties over the children's needs by delegating an essentially unfettered power to parents who are in the midst of emotional turmoil.

The possibility that some parents may seek to avoid the responsibility for caring for their children has not escaped judicial recognition. Dissenting in *Kent v. United States,* 401 F.2d 408 (D.C. Cir. 1968), Mr. Chief Justice (then Circuit Judge) Burger commented,

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the prospective patient, who showed signs of mental illness); Kaufman, et al., *Treatment Implications of a New Classification of Parents of Schizophrenic Children,* 116 *Am. J. Psychiat.* 620 (1960); Stabenau, et al., *A Comparative Study of Families of Schizophrenics, Delinquents, and Normals,* 28 Psychiatry 45 (1965) ("It has long been recognized that for many troubled parents, the most acceptable way to seek help for themselves is to seek it, instead, for their child. The overt wish to have the child treated masks, in very many cases, the covert wish of parents to have themselves treated . . . ."); Rinsley and Hall, *Psychiatric Hospital Treatment of Adolescents,* 7 Arch. Gen. Psychiat. 286, 287 (1962).



> Lawmakers in recent years have been sensitive to the need to make civil commitment difficult recognizing the danger of relatives "farming" out their kindred into mental institutions for motives not always worthy. 401 F.2d 416 n.4.

In *New York State Association for Retarded Children, Inc. v. Rockefeller,* 357 F. Supp. 752, 762 (E.D.N.Y. 1973), the court admonished:

> There may be a fundamental conflict of interest between a parent who is ready to avoid the responsibility of caring for an abnormal child and the best interests of the child. [citation omitted].

And in a similar vein the North Carolina Supreme Court has concluded:

> The parent's admission of a child to a treatment facility may result from a variety of factors, and it is possible that not all of these factors stem from a legitimate concern for the child (citation omitted). *In re Long,* 25 N.C. App. 702, 214 S.E. 2d 626, 629 (1975).

*Amicus* is not contending that most parents who seek to commit their children are doing so for nefarious or ulterior reasons unrelated to what the parents perceive as the best interests of their children. The fact is, however, as the record below demonstrates,[49] some

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[49]From the Summaries of Selected Patients which are set forth in the Record, it is ineseapable that some children have been placed in mental hospitals for reasons other than their own need for treatment. *E.g.,* Report of Psychologist: "Mother shows considerable immaturity and inadequacy in handling children . . . ." (348a) Reason for Placement: "Poor family situation—mother does not get along with patient well. The family is '. . . afraid that the mother would have another nervous breakdown if it (placement) was not done soon.'" (354a) Psychological Report: "Since there

parents do have hidden agendas. Even the most well-intentioned parents may unconsciously attempt to shift the responsibility for their own or shared difficulties upon their children, while other parents may be responding hastily or unwisely to the pressure of familial dysfunction of which they are both a participant and a cause. It is difficult for parents to make rational choices when they feel the pressure of family problems, especially when the decision to place a child in a state mental hospital entails an expertise about the treatment of mental illness, and the existence of less intrusive methods of treatment, which the ordinary parent will usually not possess.

**4. Children and Parents Who Disagree as to the Appropriateness of Institutionalization are in a Position of Fundamental Conflict of Interest.**

There is, therefore, manifest potential for conflict of interests when parents seek the commitment of their children to mental hospitals. Where such potential conflicts exist, courts have not been reluctant to act in order to safeguard the independent interests of the child.[50] Due process procedures are the preferred

is a lack of community facilities which can provide emergency placement it is being recommended that this child be placed at Polk State School and Hospital for a period of 1 or 2 weeks so that the other family members can go on a family vacation." (357a)

[50]*See, e.g., McBridge v. Jacobs,* 247 F.2d 595 (D.C. Cir. 1957) (parent may not waive minor's right to counsel); *Horacek v. Exon,* 357 F.Supp. 71 (D. Neb. 1973) (separate guardian ad litem appointed to represent children suing to remedy conditions in state home for retarded); *State v. Wade,* 527 P.2d 753 (Ore. App. 1974), *appeal dismissed.* 96 S.Ct. 16 (1975) (because of potential conflict in all parental termination proceedings appointment of separate counsel for children is mandatory); *Melville v. Sabbatino,* 30 Conn. Supp. 320, 42 U.S.L.W. 2242 (1973) (minors over age of 16 can sign themselves out of mental hospitals even if their



and appropriate mechanism for ensuring that the best interests of the child will be considered independently of his parents' desires. The child's fate should not be clouded by a variety of parental pressures and concerns which, although pertinent to the treatment inquiry, ought not be dispositive. See *Heryford v. Parker,* 396 F.2d 393 (10th Cir. 1968); *Saville v. Treadway, supra; In re Long, supra.*

**5. Two Psychiatric Evaluations, One of Which is Performed by the Committing Hospital, are an Inadequate Substitute for a Due Process Hearing.**

Although appellants argue that the uncertainty of psychiatric diagnosis has been exaggerated, they concede a "relative" amount of uncertainty which, in their view, emphasizes the "questionable wisdom" of having medically "untrained" judges oversee the recommendations of professional psychiatrists.[51] The recent literature which *Amicus* has reviewed controverts appellants' argument. At the very least, there is considerable question as to the ability of psychiatrists, not only to predict dangerousness, but even to agree in

parents have admitted them); *In re Henry G.,* 28 Cal. App. 3d 276, 104 Cal. Rptr. 585 (1972) (error to preclude minor's counsel from inquiring into whether alleged breakdown in parental control resulted from mother's failings); *In re Smith,* 16 Md. App. 209, 295 A.2d 238 (1972) (minor's mother has no power to compel minor to undergo abortion against her will); *In re Anonymous,* 42 Misc. 2d 572, 248 N.Y.S.2d 608 (Nassau Co. Ct. 1964) (adoptive parent's application to commit ten year old child to mental hospital denied because minor's hallucinations caused by rejection of adoptive parents); *In re Sippy,* 97 A.2d 455 (Ct. of App., D.C. 1953) (where interests of mother and minor are sharply opposed regarding commitment of the minor to a "psychiatric school," the mother's attorney cannot purport to represent the minor.)

[51]Brief for Appellants at 42-43.

their most gross psychiatric diagnoses.[52] Given the demonstrable unreliability of psychiatric diagnosis, it is difficult to comprehend why appellants place so much reliance upon such a relatively crude instrument as a protector of the minor's liberty.

Under the Pennsylvania "voluntary" commitment system for minors, two psychiatric evaluations are required. First, there must be a referral from a recognized medical facility, mental health/mental retardation therapist, or mental health agency. The referral must be accompanied by a psychiatric evaluation indicating ". . . with specificity the reasons that the prospective patient requires institutional care."[53] Second,

[52]*See* Rosenhan, *On Being Sane in Insane Places,* 13 *Santa Clara Law.* 379 (1973) (8 sane persons, feigning mental illness, were admitted to mental hospitals and diagnosed as schizophrenic or manic-depressive; when released, none of the persons was considered by the hospital staff to be cured). Ennis and Litwack have reviewed the pertinent literature exhaustively and conclude that if a psychiatrist testifies that a patient falls into a specific, non-organic diagnostic category, ". . . it is more likely than not that a second psychiatrist would disagree." Ennis and Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom,* 62 *Cal. L. Rev.* 693, 702 (1974). In one experiment, twenty-seven experienced psychiatrists, all members of the same hospital, used a standardized set of statements to rate patients presented to them in a half-hour filmed interview. The psychiatrists ". . . were unable to agree as to the patient's diagnosis, prognosis, psychodynamics, the cause of her problems, the feelings she was consciously experiencing or the feelings that were latent . . ." Stoler and Geertsma, *The Consistency of Psychiatrists' Clinical Judgments,* 137 *J. of Nerv. Mental Dis.* 58, 64 (1963). In still another study, two skilled psychiatrists diagnosed twenty hospital patients for depression. Both psychiatrists labeled six of the twenty patients as depressed, but they did not choose the same six! Cherry and Cherry, *The Common Cold of Mental Ailments: Depression, New York Times Magazine,* Nov. 25, 1973 at 38; *see* Roth, Dayley and Lerner, *Into the Abyss: Psychiatric Reliability and Emergency Commitment Statutes,* 13 *Santa Clara Law.* 400 (1973).

[53]Pa. Dept. of Public Welfare, Pa. Bull., Vol. 3 at 1840, Sept. 1, 1973.



there must be an examination by the director of the mental hospital or by a staff member to determine if the patient is in need of "care" or "observation".[54] Neither the statutes nor the regulations specify precisely who will conduct the latter evaluation, how quickly it must be performed, or what the standard (other than need for care or observation)[55] will be for continued confinement.

It is arguable that many, if not most, persons in our society would benefit from some form of psychiatric treatment. The problem with the Pennsylvania scheme is that it fails to distinguish between those persons who would benefit from psychiatric treatment and those who require institutionalization. One examining psychiatrist might seek to hospitalize only persons who suffer from some form of psychosis. Another psychiatrist might wish to commit persons who suffer

[54]Pa. Stat. Ann. tit. 50, §§4402 and 4403.

[55]A number of courts have invalidated mental commitment standards which were based upon a determination as to whether a person is in need of care or treatment. These courts have insisted that involuntary confinements to mental institutions be limited to persons who have shown a propensity for harm to themselves or others. *Bell v. Wayne County Gen. Hosp. at Eloise,* 384 F.Supp. 1085 (E.D. Mich. 1974) (three-judge court) (imminent threat of physical harm to prospective patient or others); *Lynch v. Baxley,* 386 F.Supp. 378 (M.D. Ala. 1974) (three-judge court) (overt act showing real and present threat of substantial harm to prospective patient or others); *State ex rel. Hawks v. Lazaro,* 202 S.E. 2d 109, 123 (W. Va. 1974) (self-destructive urge or person will permit himself to die of starvation or lack of care); *Commonwealth ex rel. Finken v. Roop,* 234 Pa. Super. 155, 339 A.2d 764 (1975) (overt act raising substantial likelihood of future dangerous acts); *see Humphrey v. Cady,* 405 U.S. 504, 509 (1972) (dicta).

from character disorders or exhibit psychopathic personalities. Still another might insist upon a showing of dangerousness to self or others. And a fourth psychiatrist might require that the patient be likely to receive suitable treatment for his mental disorder in the hospital where he will be confined. Pennsylvania delegates complete discretion for these decisions to the psychiatrist without assuring that there will be any overview of the psychiatrist's judgment. Placing only the psychiatrists between the parent and hospitalization of the child, the Pennsylvania scheme does nothing to protect against the unnecessary hospitalization which is certain to occur given the inadequacies of the psychiatric diagnoses referred to above. Moreover, these inadequacies in diagnoses are made more serious by the utter lack of standards under Pennsylvania law to govern placement of minors in mental hospitals. Hence, the Pennsylvania scheme provides only an unsystematic, haphazard, and largely ineffectual check upon parental discretion.

It is also important to recognize the conditions under which psychiatrists in both mental hospitals and community mental health centers evaluate the children for possible commitment purposes. As Professor Stone has noted,

> The feeling of crisis which attends the process of emergency confinement rarely permits the full exploration of the patient's competence. Stone, *Mental Health and Law: A System in Transition* 48, National Institute of Mental Health (DHEW Pub. No. (ADM) 75-176, 1975).



Not only are many community mental health centers and mental hospitals understaffed[56] but equally significant, most physicians

> learn early in their training that it is far more culpable to dismiss a sick patient than to retain a well one. Scheff, *Being Mentally Ill: A Sociological Theory* 110 (1966)

This has led to the conservative bias of almost all psychiatrists in favor of over-diagnosing mental illness,[57] as contrasted with the criminal law's presumption that defendants are both innocent and sane. It is understandable that a physician trained in treating illness would prefer to commit a healthy person to a mental hospital rather than allowing a mentally ill person to go free, but such a practice is hardly consistent with the constitutional guarantee that liberty shall not be infringed without due process of law.

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[56]Mechanic, *Some Factors in Identifying and Defining Mental Illness*, 46 *Mental Hygiene* 66 (1962).

[57]Scheff conducted a study of mental commitments drawn from psychiatrists' ratings of a sample of patients newly admitted to public mental hospitals in a Midwestern state. He found that in two-thirds of the hospitals the examinations were perfunctory and virtually never resulted in findings of health. In some instances the decision to retain a patient was reached even when no evidence of any mental disorder could be found. Scheff, *Being Mentally Ill: A Sociological Theory* 142 *et seq.* (1966).

Mechanic reports that in two mental hospitals studied over a period of three months he ". . . never observed a case where the psychiatrist advised the patient that he did not need treatment. Rather, all persons who appeared at the hospital were absorbed into the patient population regardless of their ability to function adequately outside the hospital." Mechanic, *Some Factors in Identifying and Defining Mental Illness*, 46 *Mental Hygiene* 66, 70 (1962). Brown has referred to the practice of large state mental hospitals which admit "everyone sent for hospitalization." E. L. Brown, *Newer Dimensions of Patient Care*, pt. I, at 60 (1961).

Finally, given the inherent bias of the psychiatrist in favor of finding illness, and the time and resource constraints upon the initial evaluation, the fact that a parent has decided that a child is sufficiently mentally ill to warrant his institutionalization is likely to substantially predispose the physician to join in the parent's appraisal.[58] Even a physician who questions the parent's evaluation is likely to approve the commitment in order to provide sufficient time for a thorough examination and diagnosis. Once the child is present in the mental institution, there is considerable evidence that he may adopt the "deviant" behavior of other patients as his own, thus confirming the institution's diagnosis.[59] And even if evaluation ultimately results in the minor's discharge, he already will have suffered a considerable deprivation of liberty warranting due process protection. *See, e.g., Bell v. Burson,* 402 U.S. 535 (1971); *Black Coalition v. Portland School District No. 1,* 484 F.2d 1040 (9th Cir. 1973).

**6. Mature, Intelligent and Competent Adolescents Should Not Be Disqualified From Participating in the Judicial Process Simply Because They Are Minors.**

*Amicus* believes that a final factor which should be accorded substantial weight in any decision affecting

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[58] "[W]here the parent admits a child for treatment, the examining doctor may quite naturally identify with the interest of the parent. If [this], happen[s], the doctor would be unable to act effectively as a screening agent at the initial stage of examination." *In re Long,* 25 N.C. App. 702, 214 S.E. 2d 626, 629 (1975); *see* Scheff, *Being Mentally Ill: A Sociological Theory* 149 (1966).

[59] See E. Goffman, *Characteristics of Total Institutions,* in *Symposium on Preventive and Social Psychiatry* (1957); H. Dunham and S. Weinberg, *The Culture of the State Mental Hospital* (1960).



vital interests of a child is the child's capacity to make mature, intelligent, and competent decisions about what is in his best interests. The Pennsylvania statutory scheme is anomalous in vesting total discretionary power in the parent irrespective of the child's age, maturity, or competence. Pa. Stat. Ann. tit. 50 §§4202 and 4203. No child may place himself in a state mental hospital, whereas any parent—irrespective of age, intelligence, competence, or motive—may place his child in a state hospital subject only to the approval of two psychiatrists. These Pennsylvania statutory provisions are overbroad in creating irrebutable presumptions that all minors are incapable of making reasoned and competent decisions as to whether their custodial treatment in state mental institutions is desirable and appropriate. Whereas many minors are, in fact, not competent to make such decisions, this Court has never intimated that all children are *per se* incapable of waiving their constitutional rights. *See Gallegos v. Colorado,* 370 U.S. 49 (1962); *Haley v. Ohio,* 332 U.S. 596 (1948). To the contrary, in *Planned Parenthood of Central Missouri v. Danforth,* 44 U.S.L.W. 5197 (U.S. July 1, 1976), this Court recognized the independent right of mature, competent minors to participate in the decision as to whether to terminate their pregnancies. 44 U.S.L.W. at 5204. In creating an all-inclusive, irrebutable presumption, the Pennsylvania procedure

> . . . forecloses the determinative issues of competence and care . . . [and] needlessly risks running roughshod over the important interests of both parent and child. *Stanley v. Illinois,* 405 U.S. 645, 657 (1972).

Such irrebutable presumptions have traditionally been disapproved by this Court, and have been found unconstitutional in a number of cases. *See Vlandis v. Kline,* 412 U.S. 441 (1973); *Stanley v. Illinois, supra; Carrington v. Rash,* 380 U.S. 89 (1965).

The National Institute of Mental Health's *Draft Act Governing Hospitalization of the Mentally Ill* (Pub. Health Services Pub. No. 51, 1951) establishes sixteen as the age at which persons should be able to seek hospitalization on their own initiative or, once hospitalized, request their own release. The Act's *Commentary* however, argues for an even lower age based upon the legal capacity of adolescents to consent to surgery or their legal responsibility for criminal conduct.

In Pennsylvania, the age of criminal responsibility is fourteen. Pa. Stat. Ann. tit. 11, sec. 260; *see Commonwealth v. Frisby,* 451 Pa. 16, 301 A.2d 610 (1973). In many other respects Pennsylvania law treats minors as capable of making important decisions in their own best interests. Minors over the age of twelve years must consent to their own adoptions. Pa. Stat. Ann. tit. 1, § 2. Minors over the age of sixteen, who are of sufficient mental ability, may become emancipated by their own acts or the acts of their parents. Pa. Stat. Ann. tit. 62, §2331(f). Finally, service of pleadings is required in any legal action upon a defendant above the age of fourteen. Pa. Stat. Ann. tit. 12, §362. These statutes are generally in accord with the overwhelming consensus of developmental psychologists that a child of twelve or thirteen begins to develop significant mental capacity which, by age sixteen, is firmly established.[60]



Commendably, Pennsylvania has acted, albeit belatedly, to accord minors over the age of thirteen years certain rights. These include the right to notification that the minor may challenge the grounds for his institutionalization; the right to a hearing under Pa. Stat. Ann. tit. 50, §4406; and the right to be furnished the telephone number of counsel whom the minor may call for representation.[61] The regulations, however, fall short of treating even mature adolescents as capable of assuming responsibility. No minor may volunteer himself for treatment. No minor may receive treatment pursuant to Pa. Stat. Ann. tit. 50, §§4402 and 4403 without parental consent. And many of the procedural rights which were held to be an integral aspect of due process by the court below are denied even those minors who are over the age of thirteen. These include the right to a probable cause determination as to the grounds for institutionaliza-

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[60]The person who has pioneered in this area has concluded that qualitative changes in the direction of adult thought begins at age 12-13. J. Piaget, *The Moral Judgment of the Child* (1932). *See* Note, *State Intrusion into Family Affairs: Justifications and Limitations,* 26 *Stan. L. Rev.* 1383, 1395-97 (1974): "Beginning in early adolescence, the child is able to deal with abstract concepts and ideals such as love, equality, and society [citing J. Hill and J. Shelton, *Readings in Adolescent Development and Behavior* 84 (1971)], and to anticipate and evaluate future consequences." 26 *Stan. L. Rev., supra,* 1395 n. 66. *See* Adelson and O'Neil, *Growth of Political Ideas in Adolescence: The Sense of Community,* 4 *J. Pers. and Soc. Psychol.* 295 (1966). By age 16 the cognitive transformation is basically completed and adult mental operations are firmly established. *See* Elkind, *Egocentrism in Adolescence,* 38 *Child Develop.* 1025, 1032 (1967).

[61]Pa. Dept. of Public Welfare, Pa. Bull., Vol. 3, at 1840, Sept. 1, 1973.

tion; the right to a reasonably prompt post-commitment hearing; the right to appointed counsel if indigent;[62] the right to confrontation and cross-examination; the right of the minor to be present at the §406 hearing; and the right to have the basis for the minor's commitment established by "clear and convincing evidence".

Although *Amicus* supports the initial steps that Pennsylvania has taken in recognizing the developmental distinctions between immature minors and older adolescents through enactment of regulations pursuant to Pa. Stat. Ann. tit. 50, §§4402-03, nevertheless, the regulations themselves cannot be said to actually accord mature, competent minors a meaningful role in the commitment decision. The regulations authorize involuntary commitment of a minor for an indefinite period of time before any justification for such a confinement can be scrutinized at a judicial hearing. And they fail to guarantee that at the hearing which may be held subsequently, minors will be provided rights long considered fundamental to due process. Thus, although belatedly offering some minors a semblance of due process, Pennsylvania has failed to establish procedures or safeguards commensurate either with the rights that are being infringed or with the potential consequences that are being imposed.

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[62]The Pennsylvania regulations only require that minors over the age of thirteen be given the telephone number of the public defender or local legal services office. They do not provide that the minor has a right to counsel in the event that the public defender or legal services attorney is incapable or unwilling to represent the minor.



## CONCLUSION

For the foregoing reasons, and for the reasons stated in the brief of Appellees, *Amicus* urges that this Court affirm the judgment below.[63]

Dated, San Francisco, California,
July 28, 1976.

Respectfully submitted,
ROBERT L. WALKER,
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By: PETER B. SANDMANN,
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[63]Counsel for *Amicus* wish to express their appreciation for the assistance of Renee Torres and Sheila Gropper in the preparation of this brief.

Supreme Court, U. S.
FILED
AUG 4 1976
MICHAEL RODAK, JR., CLERK

IN THE

# Supreme Court of the United States

OCTOBER TERM, 1976

No. 75-1064

JACK B. KREMENS, Individually and as Hospital Director of Haverford State Hospital; FRANK S. BEAL, Individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; WILLIAM B. BEACH, JR., Individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,
Appellants,

v.

KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND, Minors, Through Their Next Friend, Individually and on Behalf of All Others Similarly Situated,
Appellees.

## BRIEF AMICUS CURIAE OF MICHIGAN LEGAL SERVICES AND LEGAL SERVICES OF EASTERN MICHIGAN, AND APPENDIX

On Appeal from the Judgment of the United States District Court for the Eastern District of Pennsylvania

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August 6, 1976

Michael Rodak Jr.,
Supreme Court of the United States
Office of the Clerk
Washington, D.C. 20543

Re: Jack B. Kremens, etc., et al.,
v. Kevin Bartley, et al., No. 75-1064

CORRECTION OF ERROR
In Brief Amicus Curiae of Michigan
Legal Services of Eastern Michigan,
And Appendix

Dear Mr. Rodak:

Enclosed please find 40 copies of this letter and accompanying Proof of Service correcting an error in the State of Position of Amicus Curiae on pages 6 and 7.

The entire text of the firt three paragraphs ending at footnote 7 is a direct quote from a Michigan Auditor General Report. The quote is fully set out in Appendix C.

As a quote it should have been indented appropriately.

Respectfully,

Gabe Kaimowitz

Gabe Kaimowitz

GK/sm

Enclosures

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IN THE

# Supreme Court of the United States

OCTOBER TERM, 1976

No. 75-1064

**JACK B. KREMENS, Individually and as Hospital Director of Haverford State Hospital; FRANK S. BEAL, Individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; WILLIAM B. BEACH, JR., Individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,**
**Appellants,**
**v.**
**KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND, Minors, Through Their Next Friend, Individually and on Behalf of All Others Similarly Situated,**
**Appellees.**

## BRIEF AMICUS CURIAE OF MICHIGAN LEGAL SERVICES AND LEGAL SERVICES OF EASTERN MICHIGAN, AND APPENDIX

### INTEREST OF *AMICUS CURIAE*

Michigan Legal Sevices and Legal Services of Eastern Michigan are non-profit charitable organizations funded by the Public Legal Services Corporation to provide

specialized civil legal services to eligible clients. They have offered such assistance in juvenile and mental health law since August, 1970, and through litigation and legislative reform, have fostered the rights of: minors,[1] persons deprived of fundamental rights,[2] and persons said to be mentally ill or mentally retarded to be free from State and/or institutional abuse, particularly unwarranted and unnecessary incarceration.[3]

Michigan Legal Services and Legal Services of Eastern Michigan are currently involved in numerous cases in the federal and State courts of Michigan on behalf of minors and adults alleged to be mentally ill or mentally retarded who will be directly affected by the outcome of this

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[1]See, e.g., *Garvin* v. *Rosenau*, 455 F.2d 233 (6th Cir. 1972) (minors' right to pursue First Amendment aims in public schools); *Buckholz* v. *Leveille*, 37 Mich. App. 166, 194 N.W. 2d 427 (1971) (minor's right to access to court when in conflict with the interests of parents and school authorities).

[2]See, e.g., *Reist* v. *Bay Circuit Judge*, 396 Mich. 326, 241 N.W. 2d 55 (1976) (right to court-appointed counsel and free transcript for indigent parents in appealing the termination of their parental rights by the State).

[3]See, e.g., *Bell* v. *Wayne County General Hospital*, 384 F. Supp. 1085 (E.D. and W.D. Mich. 1974) (three-judge court) (right of adults alleged to be mentally ill to be free from unwarranted institutionalization and physically intrustive treatment).



litigation.[4] Both legal services organizations have acted and continue to act on behalf of eligible clients and at the request of State legislators to bring about changes in the Michigan Mental Health Code[5] and a proposed Juvenile Code.[6]

The purpose of Michigan Legal Services and Legal Services of Eastern Michigan in representing minors subjected to institutionalization in Michigan mental health facilities and appearing as *amicus curiae* in this action was best stated by the Michigan Court of Appeals in *Buckholz* v. *Leveille*, *supra* note 1, at 167:

> Courts must stand prepared to protect the rights of all citizens, including teenagers. Denying a teen-aged litigant access to our courts simply because he happens to be a minor not only tends to lessen the confidence of young people in our legal system but adds credence to the existence of the "generation gap". And it may even help widen that gap.

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[4]See, e.g., *Schultz* v. *Borradaile*, No. 74-4012 (E.D. Mich., filed October 25, 1974) (three-judge court) (right of adults alleged to be mentally retarded to due process and equal protection of the law before they can be subjected to guardianships and administrative admission to State institutions); *White* v. *Director of the Michigan Department of Mental Health*, No. 75-10022 (E.D. Mich. filed March 7, 1975) (three-judge court) (right of a person to damages for unlawful institutionalization in a public health facility by Michigan in *loco parentis* when she was a minor); *Wojciehowski* v. *Director of the Michigan Department of Mental Health*, No. 75-72318 (E.D. Mich., filed November 24, 1975) (three-judge court) (right of minors alleged to be mentally ill or emotionally disturbed to due process and equal protection of the law before they are institutionalized in State mental health facilities); *Jobes* v. *Michigan Department of Mental Health*, No. 74-004-130-DC (Wayne County Cir. Ct. Mich., 1974) (right of minors, alleged to be mentally ill or mentally retarded, to due process and equal protection of the law before they can be placed in State mental health facilities and used for medical research and experimentation).

[5]MCLA 330.1001 *et seq.*

[6]HB 4704, introduction March 20, 1975.

## SUMMARY OF ARGUMENT

Minors have constitutional rights, independent of rights granted to parents or the State. When their expressed constitutional right to liberty is at stake, minors should be afforded due process of law. When their confinement is threatened in a state institution, regardless of whether that facility is called a jail, receiving home, industrial school, residential treatment center, or mental hospital, minors should be entitled to the full panoply of rights at a judicial hearing.

Such a judicial hearing should be no different from one afforded to a minor charged with delinquent acts or anti-social behavior, since similar conduct often is the justification for confinement in a mental health facility. Therefore, minors being "volunteered" for admission in state mental health facilities constitutionally should be entitled to receive notice of the reasons for institutionalization, right to counsel and, if indigent, appointment of counsel, the right to confront witnesses and cross-examine them, and the protection of the privilege against self-incrimination.

In the mental health process, minors euphemistically are "volunteered" for confinement in state institutions, although they in fact cannot enter on their own, even if they are 16, 17, or, in some states, 18 or 19 years old. Some adult must consent to their entry. Under State laws, even those older teenagers are unable to use state mental health facilities as adults do who seek treatment on their own. Without authorization by the State, albeit in consultation with parents, guardians, or persons in *loco parentis*, minors cannot leave the facilities, as adults could who are similarly confined. For all intents and



purposes, they are confined at the discretion of the State since, under Pennsylvania or Michigan law, they cannot be heard in court without the assistance of the public institutions in which they are confined, except under unusual circumstances. Experience reveals that state mental hospitals do not always cooperate with minors who object to confinement, and the objections then go unheard.

The conflict then which is present in the case and controversy before this Court is between the State, which is authorized by law to accept people into public mental institutions, and the minors themselves, not necessarily one between minors and their parents or persons acting in *loco parentis* to them. Again this is the same kind of conflict adjudicated daily in state juvenile court systems throughout the country.

Since the issue is one of state mental health professionals acting under color of law to receive the minors, the *full* impact of the Due Process Clause in the United States Constitution must be applied to protect young people from unbridled discretion, however benevolently motivated, by the State.

The hearing therefore must be timely held, *before* the minors can be denied access to judicial scrutiny by being placed in total institutions, and at a time when they are at large to utilize the legal resources necessary to protect them from unwarranted institutionalization.

## STATEMENT OF POSITION OF *AMICUS CURIAE*

**I. IT IS THE BELIEF AND EXPERIENCE OF MICHIGAN LEGAL SERVICES AND LEGAL SERVICES OF EASTERN MICHIGAN THAT MINORS HAVE BEEN AND WILL CONTINUE TO BE INCARCERATED AT DIRECTION OF MENTAL HEALTH PROFESSIONALS IN PUBLIC FACILITIES IN MICHIGAN. WHEN PARENTS, GUARDIANS OR PERSONS ACTING IN *LOCO PARENTIS* ARE UNABLE OR UNWILLING TO PROVIDE CARE AND CUSTODY FOR THESE MINORS BECAUSE OF FAMILY AND RELATED PROBLEMS, MINORS WILL CONTINUE TO BE INSTITUTIONALIZED, OFTEN UNNECESSARILY, UNLESS THEY ARE AFFORDED DUE PROCESS OF LAW FOR THE REASONS STATED IN THE DECISION OF THE LOWER COURT IN *BARTLEY* V. *KREMENS*, 402 F. SUPP. 1039 (E. D. PA. 1975).**

Our review of resident (family care) case files disclosed that the center's staff had determined that five residents in family care homes are not mentally retarded or epileptic. The residents had been transferred to Caro Regional Center from another State institution in March and July, 1972. The residents had been originally committed due to early cultural deprivation.

These five residents have been under the jurisdiction and funding (100% State funds) of the Department of Mental Health for a cumulative total of 49 years. They remained under department jurisdiction and funding for a cumulative total of 32 years after individual determinations were made that they were not retarded.



Since they have normal intelligence, they do not require the level of care purchased by the center, but rather the less expensive level of foster care available to foster children provided by the Department of Social Services. Center personnel agreed with us and extensive efforts have been made to remove the residents from the jurisdiction of the Department of Mental Health. However, because of the lack of established procedures, their efforts have not been successful.[7]

Recognizing the danger described above by the "volunteering" of persons, especially minors, for institutionalization which could continue for months or years without any assurance of "cure", a majority of a three-judge court in *Bartley* v. *Kremens*, 402 F. Supp. 1039 (E. D. Pa. 1975), ordered judicial scrutiny and afforded counsel for the minors before those minors could be placed, beyond access and legal recourse, in State mental health facilities. Such judicial hearings should be required by this Court in its review of the decision below in *Bartley* v. *Kremens*, *supra*. Rights granted to juveniles by this Court in *In re Gault*, 387 U.S. 1 (1967), should be assured to minors "volunteered" for admission to State mental health facilities.

The process hardly can be called "voluntary" when under Pennsylvania or Michigan law, a minor who is 16 or 17 *cannot get treatment* unless and until his parents, guardians, or persons in *loco parentis* consent to the minor's institutionalization; and even if he loudly and

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[7]Mich. Aud. Gen. Audit Report, *Caro Regional Center, Department of Mental Health, April 1, 1971-April 30, 1974* (July 10, 1975).

vocally refused consent, he still can be "volunteered" by that same adult consenting for him. Whatever else this process may be, it certainly is not "voluntary" and should receive as much judicial scrutiny as is increasingly being given to adults who are involuntarily committed in state mental health facilities.[8]

Michigan Legal Services and Legal Services of Eastern Michigan acting on behalf of children institutionalized in State mental health facilities support the position of the Appellees in *Bartley* v. *Kremens, supra*, in the belief that minors should be allowed as much autonomy in seeking mental health care as they may in choosing abortions,[9] with whatever prior judicial review is required to assure that neither the minors nor their parents, guardians or persons in *loco parentis* are acting against the children's best interests. Without that autonomy, observed and nurtured under timely judicial scrutiny, it is likely that the Caro horror story previously described will continue to be repeated, and innocent minors will be helplessly imprisoned in institutions for months or years without meaningful access to legal resources to challenge their confinement.

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[8]*O'Connor* v. *Donaldson*, 422 U.S. 563 (1975); *Bell* v. *Wayne County General Hospital, supra* note 3.

[9]See, e.g., *Planned Parenthood of Missouri* v. *Danforth*, 44 U.S.L.W. 5197 (1976). See also *Bellotti* v. *Baird*, 44 U.S.L.W. 5221 (1976).



## II. LITIGATION INVOLVING INSTITUTIONALIZATION OF CHILDREN SAID TO BE MENTALLY HANDICAPPED IN MICHIGAN PROVIDES ADDITIONAL INSIGHT IN SUPPORT OF THE POSITION TAKEN BY APPELLEES IN *BARTLEY* V. *KREMENS, SUPRA*.

The problem of institutionalization of children said to suffer from mental disability first came to the attention of Michigan Legal Services in late 1971 when a teenager asked for legal representation to avoid being institutionalized by his parents in Hawthorn residential treatment center.[10]

Michigan Legal Services undertook the minor's representation,[11] and later obtained his release from Hawthorn after filing a writ of habeas corpus on his behalf.[12]

The next occasion Michigan Legal Services had to consider the issue was in late 1973 when a law guardian appointed by Juvenile Court asked for assistance on behalf of a seven-year-old who have been placed in a State mental health facility without a hearing and then subjected to medical research and experimentation without anyone's consent. Suit was filed in the name of the guardian *ad litem* on behalf of *all* children in State mental health facilities.[13]

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[10]See Appendix, Affidavit of Ralph D. Rabinovich, M.D. submitted with the Brief for the Michigan Association of Emotionally Disturbed Children as Amicus Curiae, hereafter referred to as Hawthorn case summaries.

[11]See Kaimowitz, *Legal Emancipation of Minors in Michigan*, 23 *Wayne L. Rev.* 19, 29, n. 38 (1972).

[12]See Appendix, Detroit News articles of January 6 and 7, 1972, concerning "Boy Challenges Commitment to Mental Institution," and "Grandparents to Take Boy Committed Against His Will."

[13]*Jobes, et al* v. *Michigan Department of Mental Health, et al.* Case No. 74-004-130-DC (Wayne Cty. Cir. Ct., MI. 1974).

Michigan Legal Services initially reached an agreement with the State Attorney General which resolved the issue of institutionalization in much the same fashion as the majority below in *Bartley* v. *Kremens, supra.*[14] The State Attorney General also took steps on his own to prevent the use of State institutionalized children for medical research and experimentation.[15]

The Michigan Association for Emotionally Disturbed Children (hereafter referred to as MAEDC) then intervened, and proceedings were conducted which resulted in the opinion provided with MAEDC's *Amicus Brief* to this Court.[16] The Association has declined to make clear the extent to which it is speaking for parents, mental health professionals or children.[17] By so doing, it has failed to acknowledge the conflicts that may arise among all three groups, especially when mental health professionals act for the State. Such conflict has been recognized in the lower Court proceedings in *Kremens* v. *Bartley, supra,* and numerous other lower Court decisions.

During the *Jobes* v. *Michigan, supra* note 4, proceedings, a mother of a nine-year-old asked Michigan Legal Services to act on her daughter's behalf and stated that, as a public assistance recipient, she was unable to

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[14]See Appendix, Stipulation for an Order, February, 26, 1974.

[15]See Appendix, Letter Opinion of February 19, 1974.

[16]See Brief of MAEDC as *Amicus Curiae* at Appendix, 4a, *Kremens* v. *Bartley*, No. 75-1064 (U.S. Oct. Term, 1976).

[17]See Brief of MAEDC as *Amicus Curiae, supra* at 2, in which MAEDC claims to represent some 2,000 parents, professionals and concerned citizens. Also see Statement of MAEDC in the Appendix submitted herewith. In that statement, the Michigan Association also seems to speak for children who wish to volunteer for institutionalization themselves, a position which has never been directly raised by that organization in court.



avoid State compulsion to have her consent to the institutionalization of her child and to that child's use for medical research purposes. The nine-year-old then was named as a plaintiff in the action.

The seven and the nine-year-old each spent more than six months on locked wards in a State mental health facility while they were being "diagnosed," but they were released months before the aforementioned opinion in that case. The case still is pending at the trial level until the State of Michigan first resolves the extent to which it will permit the use of minors in State mental health facilities for medical research purposes.[18]

Legal Services of Eastern Michigan was first asked to act on behalf of a minor placed in a public mental health facility, when a then 16-year-old's mother-in-law asked attorneys to intercede on the child's behalf. This occurred in January, 1975. It led to claims on the child's behalf which depended on whether it is lawful and constitutional for a minor to be "volunteered" against her will for institutionalization in a public mental health facility.[19]

Legal Services of Eastern Michigan, and Michigan Legal Services, which joined in representing Deborah White, the plaintiff, next were contacted by a social worker, Tom Wojciehowski. Mr. Wojciehowski asked

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[18]See Appendix, Letter of the Chairman of the Michigan House Judiciary Committee, and Emergency Rule Concerning the Use of State Mental Health Recipients in Medical Research.

[19]*White* v. *Michigan Department of Mental Health, supra* note 4. (See Appendix, Memorandum Opinion of August 6, 1975, *White* v. *Director of the Michigan Department of Mental Health, supra* at note 4, among the various opinions and orders in the *White* action and the suit brought by Tom Wojciehowski as next friend, *infra.*)

these programs to act on behalf of a then 11-year-John Doe who had designated him to take whatever steps were necessary to get him out of the State mental health facility where he was being held. The hospital refused to take any action on behalf of the child. After an attempt to intervene the boy as a party in the *White* action failed, separate suit was filed on his behalf. *Wojciehowski* v. *Director of the Michigan Department of Mental Health*, *supra* note 4.[20]

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[20]Contrary to the misrepresentations set forth on pages 8-11 of the Brief of MAEDC as *Amicus Curiae*, *supra* note 15, concerning the relationships and circumstances of the parties in *Wojciehowski* v. *Director of Michigan Department of Mental Health*, *supra* at note 4, and *White* v. *Director of Michigan Department of Mental Health*, *supra* at note 4, and the status of those cases in footnote 9 of the Brief of MAEDC as *Amicus Curiae*, *supra* note 15, the relevant facts are as set forth in the Appendix in the various Orders and Opinions of the two cases.

a. Tom Wojciehowski was found to be a suitable next friend for John Doe, after the federal court established that he had no conflict of interest because he no longer was employed or acting as big brother for the child at the institution where the minor was being held. See Appendix, Order of March 7, 1976, appointing next friend in *Wojciehowski* v. *Director of Michigan Department of Mental Health*, *supra* at note 4.

b. That Court found that there was no reason to believe he had not made a good-faith judgment to ask the child's attorneys to commence the federal court action on his behalf. *Id.*

c. That Court did deny access by next friend or the attorneys to the child, because contact "is likely to cause conflict between them and the parents and parents and the child that would not be beneficial to the child." *Id.*

d. Contrary to its statement to this Court, MAEDC is *not* a party to the *Wojciehowski* v. *Director of Michigan Department of Mental Health*, *supra* at note 4, action. The Association's attorneys ostensibly are solely involved on behalf of John Doe's parents who were permitted to intervene. (Order of March 9, 1976, granting motion of Mr. and Mrs. Doe to intervene as parties defendant.) This again raises the issue as to whether *parents* truly are represented in *Kremens* v. *Bartley*, *supra*, or similar proceedings in other states, or whether MAEDC and other groups supporting the interests of mental health professionals are riding the coattails of the family when action is brought on behalf of minors against the State.

(Cont'd on next page)



It is the belief of Michigan Legal Services and the Legal Services of Eastern Michigan programs that these situations will continue to arise haphazardly with hindrance rather than assistance of State mental health professionals, whenever a minor somehow finds access to a next friend or attorney willing to act on his or her behalf, unless orderly judicial scrutiny is imposed upon the process, as is provided for by the lower court in *Kremens* v. *Bartley*, *supra*.

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(Cont'd from preceeding page)

e. Wojciehowski is being allowed to proceed on behalf of "all persons under 18 years of age who have been, or are or will be admitted to hospitals under the Formal Voluntary Admission Sections of the Michigan Mental Health Code," applicable to children who are deemed to be clinically suitable for admission. Clinical suitability is not otherwise defined in the Michigan Mental Health Code. See Appendix, Order Certifying that Suit May Proceed as Class Action.

f. The Court rejected the argument that there was a factual basis to support the argument that representation of the class might be harmful to minors. It said that would be an issue to be considered on the merits before the three-judge court that had been convened in the case.

g. When Michigan Legal Services and Legal Services of Eastern Michigan perceived that there might be a conflict between a next friend and a minor, as they did in the Deborah White case, they moved on behalf of the child to substitute a next friend, and the Court granted the substitution. See Appendix, Order Appointing Next Friend in *White* v. *Director of Michigan Department of Mental Health*, *supra* at note 4, on March 22, 1976.

h. Although a three-judge court has been convened in *White* v. *Director of Michigan Department of Mental Health*, *supra*, as well as it has been in *Wojciehowski* v. *Director of Michigan Department of Mental Health*, *supra* at note 4, the convening judge in *White* v. *Director of Michigan Department of Mental Health*, *supra* at note 4, perceived there was no necessity to certify an additional class, because Deborah White already was represented in the class certified in *Wojciehowski* v. *Director of Michigan Department of Mental Health*, *supra* at note 4, for purposes of declaratory and injunctive relief, although she would require a next friend for her damage claim during the remainder of her minority. (See Order Denying Classification of Suit as a Class Action, dated March 22, 1976, in *White* v. *Director of Michigan Department of Mental Health*, *supra* at note 4.)

It is the experience of Michigan Legal Services and the Legal Services of Eastern Michigan program that the Formal Voluntary Admission provisions of the Michigan Mental Health Code, which resemble Pennsylvania's laws in most material respects have not basically altered the process of parents, guardians or persons in *loco parentis* "volunteering" minors into State mental health facilities where they are out of sight from and away from access to legal resources. The 1971 commitment of the teenager to Hawthorn and *Jobes* v. *Michigan Department of Mental Health, supra* note 4, arose before the Michigan Mental Health Code went into effect in August, 1974; the cases of *Wojciehowski* v. *Director of Michigan Department of Mental Health, supra*, and *White* v. *Director of Michigan Department of Mental Health, supra* at note 4, arose thereafter. Under such circumstances, this Court should look to the actual practice rather than the change in law when considering whether due process or equal protection of the laws must be applied. *Gray* v. *Sanders*, 372 U.S. 368, 372-73 (1963).

## ARGUMENT

### I.

### MINORS HAVE CONSTITUTIONAL RIGHTS INDEPENDENT OF RIGHTS GRANTED TO PARENTS OR THE STATES, ESPECIALLY WHEN THEIR LIBERTY IS AT STAKE.

The Bill of Rights and the Fourteenth Amendment are not soley limited to adults. *In re Gault*, 387 U.S. 1, 13 (1967). In *Tinker* v. *Des Moines Independent School District*, 393 U.S. 503, 506 (1969), this Court said that "(i)t can hardly be argued that either students or teachers shed their constitutional rights to freedom of speech or expression at the schoolhouse gate."



Certainly it would be anomalous to say that minors shed their right to liberty outside the institutional walls of State mental health facilities, just because the State has promised to provide services to them within. *O'Connor* v. *Donaldson*, 422 U.S. 563 (1975). As this Court stated in *Powell* v. *Texas*, 392 U.S. 514, 529 (1968):

> One virtue of the criminal process is, at least, that the duration of penal incarceration typically has some outside statutory limit; this is universally true in the case of petty offenses, such as public drunkenness, where jail terms are quite short on the whole. 'Therapeutic civil commitment' lacks this feature; one is typically committed until one is 'cured.' Thus, to do otherwise than affirm might subject indigent alcoholics to the risk that they may be locked up for an indefinite period of time under the same conditions as before, with no more hope than before of receiving effective treatment and no prospect of periodic 'freedom.'

Like the adult alcoholic, the juvenile could be assured of due process of law in a court, if the allegations of deviant behavior were considered as legal problems of delinquency and neglect rather than as mental health problems requiring "treatment."[21]

Also, distinction between "civil" and "criminal" matters has been stripped bare by this Court when the incarceration of the minor is at issue. *In re Gault, supra*,

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[21]See, e.g. *In re Gault, supra*. See also the *Hawthorn* case summaries, Brief of MAEDC as *Amicus Curiae*, Appendix, 82a-124a. *Kremens v. Bartley*, No. 75-1064 (S.C. October Term 1976) and discussion *infra* of those case summaries.

at 50. Likewise in *Powell, v. Texas, supra,* it was recognized that institutionalization of the person was the key question when sanctions, criminal or civil, were imposed. The Court emphasized the importance of the earlier case of *Robinson* v. *California,* 370 U.S. 660, (1962) in preventing the imposition of cruel and unusual punishment by incarceration for those "convicted" of "being a chronic alcoholic, being mentally ill, or a leper . . . ." *Powell* v. *Texas, supra* at 532-534. The importance of liberty to an individual who has not been convicted of what generally has been regarded as criminal behavior appears to be the thread binding the aforementioned cases, whether they concerned juveniles or adults.

This Court repeatedly has recognized the similarity between the rights of minors and the rights of adults when confinement and deprivation of liberty were at stake. See e.g. *Breed* v. *Jones,* 421 U.S. 519 (1975); *In re Winship,* 397 U.S. 358 (1970); *Kent* v. *United States,* 383 U.S. 541 (1966); *Haley* v. *Ohio,* 332 U.S. 596 (1948).

As already noted in *Tinker* v. *Des Moines Independent School District, supra,* and in a case such as *Goss* v. *Lopez,* 419 U.S. 565 (1975), in which minors were found to be entitled to some form of due process when a school suspension of less than 10 days was at stake, this Court increasingly has become cognizant of the need to protect minors from overbearing State authority in other areas of the law as well.

Most recently in *Planned Parenthood of Missouri* v. *Danforth,* 44 U.S.L.W. 5197 (1976), this Court strongly reiterated its support for the proposition that minors have constitutional rights independent of rights granted to parents or the states. The Court held that minors could



determine whether they should have abortions, or at least be entitled to judicial scrutiny if their parents or authorized agencies did not believe the decisions made by the young people were in their "best interests." See also *Bellotti* v. *Baird,* 44 U.S.L.W. 5221 (1976). In *Planned Parenthood of Missouri* v. *Danforth, supra,* at 5204, the Court decided:

> Constitutional rights do not mature and come into being magically only when one attains the state-defined age of majority. Minors, as well as adults, are protected by the Constitution and possess constitutional rights.

This Court's holding was based on the minors' implied right of privacy. Surely when the United States Constitution has given all persons, including minors, the express right to liberty, juveniles should be allowed to make their own judgment whether they wish to enter an institution or, if they are not competent because of their lack of maturity to give such consent, to benefit from judicial scrutiny to assure that they receive due process of law. Neither the Pennsylvania nor the Michigan law concerning the so-called "voluntary" admission of minors to mental health facilities guarantees young people either the right to consent or the right to a hearing *before* they are placed in institutions. See *In re Gault, supra.*

## II.

## MINORS VOLUNTEERED FOR COMMITMENT TO PUBLIC MENTAL INSTITUTIONS ARE IN CONFLICT WITH THE STATE, AND NOT NECESSARILY WITH THEIR PARENTS, GUARDIANS OR PERSONS IN LOCO PARENTIS.

The conflict between the minors and the State begins, not with the decision by the parent or person in loco parentis to commit the minor to a public facility,[22] but rather with the enactment of a statute and/or administrative regulatory scheme that delegates the

[22]Generally positive motives are ascribed to parents and guardians who volunteer children for institutionalization. They do not, however, "have a conflict-free interest in representing the child." Goldstein, Freud and Solnit, *Beyond the Best Interests of the Child*, 66 (1973). Potential and mentally abusive parents, 'scapegoating' by parents, familial 'pseudo-mutuality' and disorders within the family can result in minors being volunteered for institutionalization. See Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 Calif. L. Rev. 840, 857-862 (1974). Parental motives are not at issue here; state action, in responding to what is perceived as parental intent, is. The possibility of such conflict was recognized in *Prince* v. *Massachusetts*, 321 U.S. 158, 170 (1944), when this Court specifically noted that parents or persons in *loco parentis* could make martyrs of themselves, but not of the children in their care.



authority to commit the minors to those mental health institutions without affording them substantial procedural protections.[23]

The State has created and maintained this conflict by refusing to provide timely procedural safeguards to protect minors from unwarranted institutionalization, the same safeguards it affords in probate courts to adults being committed involuntarily, and in juvenile courts to minors being committed involuntarily because of delinquency on their part, or neglect on the part of their parents.[24]

[23]Michigan does not allow any child or adult to be hospitalized for surgical or medical treatment by any physician or surgeon, or any office or representative of the state or county departments of social welfare," contrary to the wishes of said person" unless the person is not in a position to make decisions for himself. MCLA Sec. 400.66h. Presumably some children are considered in positions to make decisions for themselves and would require a court hearing to determine their competency to do so, if mental health in Michigan is regarded as a form of medical treatment. This statutory provision has never been interpreted. See also *Bellotti* v. *Baird*, *supra*, remanded by this Court so that Massachusetts courts could determine whether state law permitted minors to consent to abortions, or receive judicial scrutiny if their parents "vetoed" their right to necessary medical procedures.

[24]Pennsylvania Mental Health and Mental Retardation Act, 50 P.S. Sections 4402 and 4403.

Furthermore, it is not the offering of the minors for institutionalization by parents or persons in loco parentis but the acceptance by the State of these children whom it finds to be clinically suitable for admission that is the case and controversy before this Court. It is not known how often the parents have acted on their own, or only moved to have their offspring committed when they were advised or told to have their children admitted for diagnosis or treatment by mental health professionals.[25] It is the state action that should be subjected to judicial scrutiny, not the motives or intent of the parents or persons acting in *loco parentis*.

Finally, while the State seeks to avoid public scrutiny of its action in accepting those deemed clinically suitable, it is the minor who inevitably suffers the consequences of not having notice of the reasons for confinement, an opportunity, with the assistance of counsel, to confront mental health professionals acting for the State, and a chance to be heard. See *Chaloner* v. *Sherman*, 242 U.S. 455 (1917). The minor winds up being placed in a total institution, away from the nurturing atmosphere of a home in the community, in a place where every aspect of his or her life is completely regulated by impersonal authority. Goffman, *Asylums*, 6 (1961). This Court long has been aware of the dangers posed by total communities to constitutional rights, because of the ability in such an environment to control the views of those within them, and to keep dissenting voices out. *Marsh v. State of Alabama*, 326 U.S. 501 (1946).

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[25]See *Jobes v. Michigan*, *supra*, note 4, and Brief of MAEDC as *Amicus Curiae*, *supra*, note 21, Appendix 4a.



In the final analysis, it is the State which creates, prolongs, or resolves the conflict rather than the minors themselves or their parents, guardians or persons acting in *loco parentis*. This would not be tolerable in our society when minors and their parents or persons in *loco parentis* are facing charges of delinquency or neglect which may result in institutionalization in youth homes or child care facilities. *In re Gault, supra*. It should not be considered any more reasonable to avoid *timely* judicial scrutiny of State action when the minors are put away to be "cured." *Powell v. Texas, supra* at 529; *Gerstein v. Pugh*, _____ U.S. _____, 95 S. Ct. 854 (1975).

## III.

**WHEN MENTAL HEALTH PROFESSIONALS, ACTING UNDER COLOR OF STATE LAW, INSTITUTIONALIZE MINORS, THE MINORS SHOULD BE AFFORDED DUE PROCESS OF LAW TO PROTECT THEM FROM THE UNBRIDLED DISCRETION, HOWEVER BENEVOLENTLY MOTIVATED, OF THE STATE.**

Institutionalization of a minor in a mental facility is the ultimate deprivation of the minor's liberty. As the Court described the analogous situation of the institutionalized juvenile in *In re Gault, supra* at 27:

> A boy is charged with misconduct. The boy is committed to an institution where he may be restrained of liberty for years. It is of no constitutional consequence — and of limited practical meaning — that the institution to which he is committed is called an Industrial School. The fact of the matter is that, however euphemistic the title, a 'receiving home' or an 'industrial school' for juveniles is an institution of

> confinement in which the child is incarcerated for a greater or lesser time. His world becomes 'a building with whitewashed walls, regimented routine and institutional hours * * *.' Instead of mother and father and sisters and brothers and friends and classmates, his world is peopled by guards, custodians, state employees, and 'delinquents' confined with him for anything from waywardness to rape and homicide.

Indeed, the so-called "voluntary" commitment of minors, who have committed no crimes and are incarcerated solely for alleged purposes of "treatment," are more severely deprived of their liberty than delinquents. They may be subjected to more serious institutional conditions such as being placed on the same ward with adults, physically attacked or abused by other patients, exposed to chronic dysfunctional behavior and forced to take drugs that serve no purpose other than to keep the minors in a constant stupor.[26]

Institutionalized persons are subjected to medical research and experimentation. See *Kaimowitz* v. *State Department of Mental Health*, 42 U.S.L.W. 2063 (July 31, 1973). A recent Annual Report of the Michigan

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[26]A recent study by the Auditor General of Michigan reported that the Michigan Department of Mental Health purchased a total of $1,331,000 in psychotropic drugs for the calendar year 1974. In a review of the records of eight State hospitals, the Auditor General found that 30% of the patients received psychotropic drugs in excess of recommended maximums, 40% of the patients received antiparkinson drugs on a routine basis or for prolonged periods, and the practice of utilizing "drug holidays" was almost non-existent. Mich. Aud. Gen. Audit Report, *Use of Psychotropic Drugs, Department of Mental Health*, 1, 3, 4 (April, 1975).



Auditor General verifies this conclusion by stating that the Michigan Department of Mental Health is "responsible for . . . promoting research of the causes and prevention of mental disorders." Mich. Aud. Gen. Ann. Report Fiscal Year Ending June 30, 1974, 115 (1974). Drug studies are an important aspect of this research.

> Audits of institutions for the mentally handicapped revealed that the institutions received monies from pharmaceutical firms as a direct result of drug studies performed. These studies were performed utilizing State-supported facilities and staff, and the monies received were retained at the institution as gifts, bequests and donations.
>
> Mich. Auditor Gen. Ann. Rep. Fiscal Year Ending June 30, 1974.

Also, the stigma of being known as an "ex-mental patient" has a serious effect on the life of the formerly institutionalized person. The "former mental patient will encounter serious obstacles in attempting to find a job, sign a lease or buy a house," even to a greater extent than an ex-felon. *Lessard* v. *Schmidt*, 349 F. Supp. 1078, 1089 (E.D. Wis. 1972), vacated and remanded on other grounds, 414 U.S. 473 (1974), on remand, 379 F. Supp. 1376 (E.D. Wis. 1974), vacated and remanded on other grounds, 95 S.Ct. 1943 (1975), on remand case No. 71C-602, (E.D. Wis. May 28, 1976).

The minor's perception of his own identity can be permanently damaged.

> The 'crazy' label can also have a powerful impact upon the self-concept of the person institutionalized, especially where that person is

young and impressionable. Scheff argues that this kind of labeling is the single most important cause of 'careers of residual deviance.' The act of labeling reverses the presumption of normality which is usually accorded a person's actions. Since the presumption of abnormality attaches to the 'former mental patient,' the amount of deviance in his or her behavior will be exaggerated in the perception of others, and perhaps in fact. Oddities of behavior which would not be noticed in a 'normal' person will be seen as proof of continued craziness in a former mental patient. Craziness will be found in these actions, and the label will be renewed and confirmed.

Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 Cal. L. Rev. 840, 870 (1974).

The institutionalization of minors has increased dramatically. The involuntary aspect of the so-called "voluntary" commitment statutes is one cause of this increase.[27] The "uncertainties" of the psychiatric process

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[27]In 1952, only 9 states had laws allowing parents to "voluntarily" commit minors. Today, most states have such laws. The accompanying increase in the number of minors in mental institutions is evident. Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 Cal L. Rev. 840, 844 (1974). For example, in 1975, the proportion of the California state hospital population under the age of 21 was 1.3 percent; in 1969, patients under 21 constituted 9.2 percent of the hospital population. Nationally, the number of hospitalized middle-aged patients has been decreasing while the number of patients between ages 15 and 24 has increased, the number of patients under age 15 increasing most sharply. Id. at 845.



is another cause of continued and increased institutionalization of minors.[28] As Chief Justice Burger stated in his concurring opinion in *O'Connor* v. *Donaldson, supra*, at 45 L. Ed 2d 396, 412:

> The Court appropriately takes notice of the uncertainties of psychiatric diagnosis and therapy, and the reported cases are replete with evidence of the divergence of medical opinion in this vexing area. E.g., *Greenwood* v. *United States*, 350 U.S. 366, 375, 76 S. Ct. 410, 100 L. Ed. 412 (1956). See also *Drope* v. *Missouri*, 420 U.S. 162, 95 S. Ct. 896, 43 L. Ed. 2d 103 (1975).

Institutionalization of minors and the resulting severe deprivations of liberty, dignity and the pursuit of happiness dramatically illustrate the need for substantial due process safeguards.

> There can be no doubt that involuntary commitment to a mental hospital, like involuntary confinement of an individual for any reason, is a deprivation of liberty which the State cannot accomplish without due process of law. *Specht* v. *Patterson*, 386 U.S., at 608, 18 L. Ed. 2d 326, 87 S. Ct. 1209. Cf. *In re Gault*, 387 U.S. 1, 12-13, 18 L. Ed. 2d 527, 87 S. Ct. 1428 (1967). Commitment must be justified on the basis of a legitimate state interest, and the reasons for committing a particular

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[28]Recent experiments by Dr. David L. Rosenhan dramatize the extent of incorrect diagnosis resulting in institutionalization. In the experiment involving eight normal patients who sought admission to twelve different hospitals, exhibiting only the hearing of voices saying something like "empty" or "thud", all eight "pseudopatients" were admitted to each of the twelve hospitals with a diagnosis of schizophrenia or manic-depressive psychosis. Rosenhan, *On Being Sane in Insane Places*, 13 *Santa Clara Law*. 379, 381 (1973).

individual must be established in an appropriate proceeding.

*O'Connor* v. *Donaldson, supra* see 45 L. Ed. 2d 396, 410 (Burger, C.J. concurring)

Unlike the criminal process which has a statutorily fixed outside limit of incarceration, persons committed to mental institutions "may be locked up for an indefinite period of time under the same conditions as (jail) . . . and no prospect of periodic 'freedom'." *Powell* v. *Texas, supra* at 529. "Where, as in both proceedings for juveniles and mentally deficient persons, the state undertakes to act in *parens patriae*, it has the unescapable duty to vouchsafe due process . . ." *Heryford* v. *Parker*, 396 F. 2d 393, 396 (10th Cir. 1968).

In *In re Gault, supra*, the Court said that "(t)he problem is to ascertain the precise impact of the due process requirement upon such proceedings." The Court stated that the minor's deprivation of liberty was equivalent to a convicted adult in a criminal case except that the "safeguards available to adults were discarded" in the minor's case. *Id.* at 29. The Court held that the minor was entitled to receive: notice of the charges; right to counsel and, if indigent, appointed counsel; the right to confront witnesses and cross-examine them; and the privilege against self-incrimination. *Id.* at 33, 41, 55-56.

The placement of a minor in a mental institution is as much a serious deprivation of liberty as a commitment to a training school. The deprivation of liberty subject to the Due Process Clause of the Fourteenth Amendment is the same whether it emanates from proceedings labeled "ciminal" or "civil." See *In re Gault, supra*, at 50; *Specht* v. *Patterson*, 386 U.S. 605, 608 (1967).



In fact, many minors have been institutionalized for the same behavior that would have required substantial due process safeguards in a juvenile court hearing. The Brief of Amicus Curiae MAEDC provides many illustrations of typical case histories of minors at the Hawthorn Center, an institution providing "treatment, training and research in child psychiatry under the Department of Mental Health, State of Michigan."[29] Minors are confined in the Hawthorn Center for the so-called "treatment" of a "relatively affectionless personality,"[30] "chronic deprivation and neglect"[31] and "psychoneurosis,"[32]

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[29]Brief of MAEDC as *Amicus Curiae*, *supra* note 21, Appendix at 82a-124a.

[30]*Id.* at 84a, 87a, 88a, 115a, 117a-118a, 123a (minors Nos. 8, 19, 22, 119, 129, 148).

[31]*Id.* at 84a, 86a, 90-91a, 99a, 100a, 101a, 106a, 107a, 109a, 113a, 115a, 117-118a, 120a, 121a, 123a (minors Nos. 9, 14, 32, 33, 64, 69, 71, 89, 93, 99, 112, 119, 129, 132, 138, 139, 142, 148).

[32]*Id.* This term is the primary diagnosis in more than half of the Hawthorn case summaries.

The most recent *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders* (2d Ed. 1968), indicates that the term "psychoneurosis" has been discarded as a diagnostic tool but is applicable to conditions now referred to as "neurosis."

> The neuroses, as contrasted to the psychoses, manifest neither gross distortion or misinterpretation of extended reality, nor gross personality disorganization . . . .
>
> Traditionally, neurotic patients, however severely handicapped by their symptoms, are not classified as psychotic because they are aware their mental functioning is disturbed.

The danger of locking up "psychoneurotics" was set forth more than a generation ago, in a law review article cited favorably in

(Cont'd on next page)

accompanied by various acting out behavior. Such terms, without due process safeguards, allow the wrongful commitment of minors who may be unwanted by their families, mistreated or otherwise labeled "different" from other minors.

The provision of substantial due process safeguards, as are presently provided to juveniles in the juvenile justice system, will prevent wrongful institutionalization of minors and enhance the various governmental interests. The risks of erroneous deprivation, however beneficially imposed, of a minor's liberty for whatever reason, will be dramatically lessened.

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American Bar Foundation (Brakel and Rock, editors) *The Mentally Disabled and the Law* (1971):

> (The Draft Act for the Hospitalization of the Mentally Ill) would allow the indeterminate hospitalization of the severe "neurotic" or "psychoneurotic" against their will. Such a person would seldom meet the legal criterion of mental incompetency, although he might because of his illness lack sufficient insight to make a proper decision regarding his need for hospitalization or medical care. This would appear to be new law when broadly interpreted. It cannot rest on the doctrine of *parens patriae* nor can it rest on the public health or police powers of the state.
>
> Whitmore, *Comments on a Draft Act for the Hospitalization of the Mentally Ill*, 19 *Geo. Wash. L. Rev.* 512, 522-23 (1952).

The article then significantly footnotes the last point:

> The law has dealt previously with the "insane" and with "incompetency" and legal doctrine have been built around these concepts. Now we are dealing with a new term "mental illness." The definition of the term as given in the Draft Act . . . makes medical sense but when used as a criterion for involuntary hospitalization of indeterminate duration accompanied only by the finding that the sick person needs medical care and does not know it, such use would seem to be without basis in our present law. Such a provision cannot rest on the doctrine of *parens patriae* . . .; nor does it fall within the doctrine of danger to oneself or to others . . . . It

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## IV.

## MINORS ARE AS ENTITLED TO TIMELY HEARINGS BEFORE THEY CAN BE INSTITUTIONALIZED BY MENTAL HEALTH PROFESSIONALS AS THEY ARE WHEN INSTITUTIONALIZED BY JUVENILE COURT AUTHORITIES.

About 60 years ago, this Court was confronted with the problem of what to do when persons said to be incompetent to handle their own affairs were deprived of property or liberty. *Chaloner* v. *Sherman, supra*. This Court found that such persons were protected when they had notice and an opportunity to be heard. It then examined whether the state law in question had afforded such notice and opportunity at each stage of the proceedings considered vital to safeguard the individual's right to due process of law. As already noted, similiar examination has been given by this Court when a minor charged with a delinquent act was institutionalized in a State Industrial School. *In re Gault, supra*.

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> would be difficult to reconcile with the use of state power in public health. The power of the state to quarantine a person suspected of having or being exposed to a contagious disease was upheld . . . but quarantine is (a) imposed for a definitely limited period of time, (b) based on the diagnosis of illness having clearer diagnostic criteria, which may often be verified by objective scientific laboratory tests, and (c) is for the purpose of protecting the public from diseases which are known to spread from one person to another. A mental illness cannot be classified as a contagious disease. While the Draft Act is in no sense a criminal statute it does possess the basic similarity that under it the individual may be deprived of his liberty. The provision under discussion here might be attacked on the grounds of vagueness . . .

The article goes on to conjecture that the public welfare might be used to justify the confinement of "psychoneurotics but it is seriously questioned if the public welfare is sufficiently involved to support the deprivation of liberty involved." *Id.* at 523.

In *In re Gault, supra,* it was found that such a minor must receive at least notice of the charges against him, assistance of counsel, the opportunity to be heard including the right to confront and cross-examine witnesses, and the protection of the privilege against self-incrimination.

However, today, when a minor is shunted onto the mental health track, rather than up the juvenile justice system line, even though exactly the same type of conduct might be involved (see *Hawthorn* case summaries), lower courts still are uncertain whether the child is entitled to the same protection. In Michigan, a federal district court convened a three-judge court to consider some of the same issues raised by Appellees herein. It determined that the named Plaintiff could represent all persons under 18 years of age who have been, now are, or will be admitted to hospitals under the Formal Voluntary Admission sections of the Michigan Mental Health Code. Then the Court denied the minor access to his next friend or counsel in *Wojciehowski v. Michigan, supra,* note 4.[33]

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[33](T)he Court will enter no order directing either the intervening parents or the defendants to permit Mr. Wojciehowski, or counsel for plaintiff to have access to the minor child. If plaintiff's counsel become aware of any particular reason why such contact is necessary they may make a written application to the Court with notice to the other parties. The Court recognizes that this procedure may prevent Mr. Wojciehowski from becoming aware of facts that might lead him to dismiss or otherwise alter the course of this action. However, the Court is of the opinion it is in the best interest of the child that contact between the next friend or plaintiff's attorneys and the minor is likely to cause conflict between them and the parents and parents and child that would not be beneficial to the child.

See Appendix, Order of March 9, 1976, Appointing Next Friend in *Wojciehowski v. Michigan Department of Mental Health Director, supra* note 4.



Obviously, Amici herein do not agree with that position which was taken by the lower federal court in *Wojciehowski v. Michigan, supra,* note 4, but cite it as an example of how a child may be detained in a state mental health facility, and denied access to adults legally authorized to represent him, even after a Court recognizes that his constitutional right to liberty is at stake. Certainly if he were an adult, no court cognizant of constitutional rights would permit such denial of access to attorneys or next friends:

> There are a variety of ways to further the purpose served by sequestration without placing a sustained barrier to communication between a defendant and his lawyer. To the extent that conflict remains between the defendant's right to consult with his attorney during a long overnight recess in the trial, and the prosecutor's desire to cross-examine the defendant without the intervention of counsel, with the risk of improper 'coaching,' the conflict must, under the Sixth Amendment, be resolved in favor of the right to the assistance and guidance of counsel. *Brooks* v. *Tennessee,* 406 U.S. 605, 92 S. Ct. 1891, 32 L. Ed. 2d 358 (1972).
>
> *Geders* v. *United States,* 96 S. Ct. 1330 (1976), at 1337.

The fact that *Kremens* v. *Bartley, supra,* or *Wojciehowski* v. *Department of Mental Health Director, supra* at note 4, concern juveniles rather than adults, should not alter the nature of those rights, such as access

to counsel, because the State or parents might object to their having their own attorneys:

> In my view, therefore, the due process question cannot be decided upon the basis of general characteristics of juvenile proceedings, but only in terms of the adequacy of a particular state procedure to 'protect the (juvenile) from oppression by the Government,' *Singer* v. *United States*, 380 U.S. 24, 31, 85 S. Ct. 783, 788, 13 L. Ed. 2d 630 (1965), and to protect him against "the compliant, biased, or eccentric judge." *Duncan* v. *Louisiana*, 391 U.S. 145, 156, 88 S. Ct. 1444, 1451, 20 L. Ed. 2d 491 (1968). *McKeiver* v. *Pennsylvania*, 403 U.S. 528, 554, 91 S. Ct. 1976, 1991 (1971) (Justice Brennan concurring).

The Court now is being asked to examine the adequacy of the procedure under state laws that allow minors to be "volunteered" into state mental health facilities under conditions that are not applicable to adults being involuntarily committed, or to juveniles in the juvenile justice system. Again, as in *McKeiver* v. *Commonwealth of Pennsylvania*, *supra*, that State argues that a special procedure should be applied, because the mental health of these children is involved — not because these minors truly are volunteering or consenting to their admission.

This Court only recently reviewed procedures suggested by the State of Florida as being sufficient to protect people's rights prior to a criminal proceeding against them — and found them wanting for many of the same reasons which should be applicable here. *Gerstein* v. *Pugh*, *supra*:

> The issue in this case is whether a person arrested under a prosecutor's information is



> constitutionally entitled to a judicial determination of probable cause for pre-trial restraint of liberty.
>
> *Gerstein* v. *Pugh*, *supra* at 858.

In *Gerstein*, *supra*, this Court called for separate functions between those involved with the making of the arrest — the police and the prosecutor — and those who must determine whether there was probable cause to believe the arrest was warranted:

> The reason for this separation of functions was expressed by Justice Frankfurter in a similar context: 'A democratic society in which respect for the dignity of all men is central, naturally guards against the misuse of the law enforcement process. Zeal in tracking down crime is not in itself an assurance of soberness of judgment. Disinterestedness in law enforcement does not alone prevent disregard of cherished liberties. Experience has therefore counseled that safeguards must be provided against the dangers of the overzealous as well as the despotic. . . . *McNabb* v. *United States*, 318 U.S. 332, 343, 63 S. Ct. 608, 614, 87 L. Ed. 819 (1943).'
>
> *Gerstein* v. *Pugh*, *supra* at 865.

Likewise here, the State role in institutionalizing minors in mental health facilities must be separated from the judicial function of determining whether such institutionalization is justified. The State's role in "treating" the minor certainly must be separated from "assisting him to object" to hospitalization after the minor is likely to have been institutionalized.

The Court in *Gerstein v. Pugh, supra*, extensively examined the extent of the proceedings required and the timeliness of those proceedings in determining how extensive the rights of the accused should be. It relied on the extent of harm to be done, and whether the proceeding was at a "critical stage." Although it found that a probable cause hearing was not a critical stage to require an adversary proceeding, it set forth guidelines. Those guidelines would indicate when persons who might be subjected to long-term institutionalization from the time of placement in a state institution, are at a critical stage:

> The Court has identified as 'critical stages' those pre-trial procedures that would impair defense on the merits if the accused is required to proceed without counsel. (citation omitted.)
>
> *Gerstein* v. *Pugh, supra* at 867.

The Court concluded in language applicable to this matter before it:

> Whatever procedure a State may adopt, it must provide a fair and reliable determination of probable cause as a condition for any significant pre-trial restraint on liberty, and this determination must be made by a judicial officer either before or promptly after arrest.
>
> *Gerstein* v. *Pugh, supra* at 869.

Neither the State of Pennsylvania, nor the State of Michigan, has adopted a procedure that would be a fair and reliable determination of probable cause that a minor should be institutionalized in a state mental health facility, especially in light of the fact that the only real opportunity the child has for a hearing in either state comes after institutionalization, and after the State



already has determined for itself that such probably cause exists.

There must be a determination made by a judicial officer either before or promptly after the child has been institutionalized that there is probable cause to believe that the minor needs to be committed. Then in light of the long-term institutionalization that can occur if such a determination is made, the minor must be assured of some timely hearing affording him or her all of the protection provided in *In re Gault, supra*, all of the protection provided by the state juvenile justice systems.

Neither Pennsylvania nor Michigan law provide such protection.

## CONCLUSION

For the foregoing reasons, the decision of the court below should be affirmed.

Respectfully submitted,

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Date: August, 1976

## APPENDIX A

## FUND RAISING NEWSLETTER

MICHIGAN ASSOCIATION FOR EMOTIONALLY
DISTURBED CHILDREN
668 Pallister Avenue
Detroit, Michigan 48202
313/TRINITY 3-3660

July 2, 1976

Dear Members and Friends of MAEDC,

A recent development of major national importance presents MAEDC with the greatest challenge that we have faced in our 19 year history.

The United States Supreme Court has authorized MAEDC's intervention in the Pennsylvania lawsuit, *Kremens* v. *Bartley*, involving the right of the disturbed child to voluntary hospital treatment. Our participation in this lawsuit was requested by the Attorney General, State of Pennsylvania, because of our effective involvement in similar litigation here in Michigan.

As you know, MAEDC has intervened in two Michigan lawsuits to defend the right of children to voluntary hospitalization. In 1974, and again in 1975, we were compelled to enter cases which would have denied voluntary admission to children.

MAEDC has also fought for judicial protections for the child. The Objection sections of the Michigan Mental Health Code, strongly supported by us, permits any child who does not wish to be in the hospital the right to a court hearing. Equally vital, of course, is the right to voluntary admission without court intervention if the child so wishes.



The question in the lawsuit which is now before the United States Supreme Court is clear: must a child be subjected to an adversary court hearing contrary to his wishes in order to be admitted to a children's inpatient mental health program?

The decision to be made by the United States Supreme Court will be momentous. It will not only determine the disturbed child's right to voluntary treatment, it will also have a far-reaching impact on the relationships between parent and child.

## APPENDIX B

## DETROIT NEWS ARTICLES

### BOY CHALLENGES COMMITMENT TO MENTAL INSTITUTION

By MICHAEL BROGAN
News City-County Bureau

Do parents have the legal right to place a minor child — below age 18 — in a mental treatment facility against the child's wishes and without a court order?

The question is the crux of a legal battle in Wayne Circuit Court where a 15-year-old Westland boy charges he is being illegally detained at the Hawthorn Center in Northville.

The center, operated by the Michigan Department of Mental Health, treats emotionally and mentally disturbed youngsters below age 18.

The boy maintains that his placement in the center last Dec. 18 was illegal because he does not want to be there and because there have been no Probate Court hearings either to adjudge him mentally ill or to order his commitment.

The boy's charges brought a list of countercharges from lawyers for his parents and the state.

The boy's lawyer, Gabe Kaimowitz, of the Michigan Legal Service Assistance Program, a federally funded agency, says he would not have objected to the boy being placed in the center if his parents had followed correct legal procedures.

He added, however, that they did not, and the boy wants to be released and placed in a foster home.

ATTORNEY ARTHUR CARPENTER, representing the parents, says the boy has had a history of emotional disturbances and his parents are "afraid to have him at home."

Arthur D'Hondt, an assistant Michigan attorney general representing Hawthorn Center, says Wayne Circuit Court has no jurisdiction in the case; that it should be heard by Wayne Probate Court.

The boy took the witness stand yesterday and told Circuit Judge James N. Canham that although his stay at the center has been livable," I don't want to stay there.

"I would like to be placed in a foster home if that is possible. I can't get along with my parents."

He said since being placed in the center by his father, he has not been allowed to make phone calls, although he is allowed to receive them from his lawyer.

Dr. Ralph Rabinovich, clinical director of the center, who has known the boy for five years, testified that he treated him in the past and characterized him as a "severely emotionally disturbed boy in desperate need of psychiatric treatment."

Dr. Rabinovich said the boy should not stay at home with his parents because he is likely to become "aggressive and subject to sadistic rages."

Both D'Hondt and Carpenter said they consider placement of the boy in Hawthorn legal, since the boy's father signed necessary admission papers.



DR. RABINOVICH said he advised the boy's parents to send him to the center, adding that "they did so out of concern for the boy."

Kaimowitz contends, however, that the parents' action amounted to "saying that anytime they don't want a child around they can send him off to an institution without considering his legal rights or feelings."

But D'Hondt says Kaimowitz' argument is "ridiculous if carried to its very illogical conclusion."

"By following that argument," D'Hondt said, "you would have to argue that whenever a parent wanted to place a child in a hospital for a needed operation the parent would have to get a court order allowing detention in the hospital."

Kaimowitz said, however, that state laws applying to treatment of mental ailments are different than those applying to a parent's legal responsibility to care physically for a child.

The boy was placed in the Hawthorn Center after a series of incidents that began Oct. 29, when he was arrested by Ann Arbor police as a truant, the same day his parents filed a delinquency complaint against him in Wayne County Juvenile Court.

THE NEXT DAY, the boy was taken before a Wayne Juvenile Court referee for a preliminary hearing. At that time, although the youth's parents were not present, Kaimowitz said the Washtenaw County Catholic Social Services agency had arranged for a foster home for the boy.

The referee released the boy to the social services agency, but on Nov. 2 the boy's parents sought an order in Washtenaw Circuit Court to gain custody of the child.

Judge William F. Ager ordered the boy returned to his parents for a week while a new petition was filed in the Wayne Juvenile Court concerning the boy's alleged delinquency.

While that petition was pending, the boy lived with his parents. On Dec. 1, Wayne Juvenile Judge James H. Lincoln disqualified himself from hearing the case and (sent it) to Presiding Probate Judge George N. Bashara.

On Dec. 18, while hearings before Bashara were pending, the boy's father took him to the Hawthorn Center.

## GRANDPARENTS TO TAKE BOY COMMITTED AGAINST HIS WILL

By MICHAEL BROGAN
News City-County Bureau

A 15-year old Westland boy who sued to gain his release from a mental treatment center has received his parents' permission to live with his maternal grandparents.

They told Wayne Circuit Judge James N. Canham yesterday he can live with his grandparents at least until Wednesday when a hearing on a delinquency complaint they filed against their son is heard by Wayne Probate Judge George N. Bashara.

The parents placed the boy Dec. 18 in the Hawthorn Center in Northville, which treats mentally and emotionally disturbed youngsters below age 18. It is operated by the Michigan Department of Mental Health.



The boy's lawyer went into Canham's court Wednesday seeking a writ that would free him from the Hawthorn Center.

The lawyer, Gabe Kaimowitz, charged that the boy was being illegally and involuntarily held at the center because no court order had been entered adjudging him mentally ill or calling for commitment.

The parents' lawyer, Arthur Carpenter, told Canham the parents were afraid to keep their son at home.

Dr. Ralph Rabinovich, clinical director of the center, testified that the boy has a five-year history of emotional problems and is likely to become violent if frustrated.

He said the boy is in "desperate need of psychiatric treatment."

Canham said he planned to call the parents to the witness stand yesterday.

When the hearing began, the parents agreed to place the boy with his grandparents in Detroit.

Kaimowitz had said that if a court order had been issued calling for the boy's commitment, "I would have no objection."

"But it wasn't ordered and everytime a parent doesn't want a child around, the parent just can't have him committed someplace," Kaimowitz said.

## APPENDIX C

## LETTER AND SECTION 8 ON FAMILY CASE

State of Michigan
Office of
ALBERT LEE, C.P.A.,
Auditor General
Lansing

July 10, 1975

Dr. Donald C. Smith, Acting Director
Department of Mental Health
Lewis Cass Building
Lansing, Michigan

Dear Dr. Smith:

Herewith is presented our report on the audit of Caro Regional Center for the period April 1, 1971 through April 30, 1974. Our examination was made in accordance with generally accepted governmental auditing standards, and accordingly included such tests of the accounting records and other auditing procedures as were necessary.

Our comments, recommendations, description of agency, and scope of audit follow this letter.

The courtesy and cooperation extended to our auditors by your staff and the center's staff during the course of our examination is appreciated.

Very truly yours,

/s/ Albert Lee, C.P.A.
Auditor General



8. Our review of resident (family care) case files disclosed that the center's staff had determined that five residents in family care homes are not mentally retarded or epileptic. The residents had been transferred to Caro Regional Center from another State institution in March and July 1972. The residents had been originally committed due to early cultural deprivation.

These five residents have been under the jurisdiction and funding (100% State funds) of the Department of Mental Health for a cumulative total of 49 years. They remained under department jurisdiction and funding for a cumulative total of 32 years after individual determinations were made that they were not retarded.

Since they have normal intelligence, they do not require the level of care purchased by the center, but rather the less expensive level of foster care available to foster children provided by the Department of Social Services. Center personnel agreed with us and extensive efforts have been made to remove the residents from the jurisdiction of the Department of Mental Health. However, because of a lack of established procedures, their efforts have not been successful.

We recommend that the center in conjunction with the Department of Mental Health, the Department of Social Services, and the Probate Court develop a procedure whereby the children can be released from Department of Mental Health jurisdiction and returned to the court's jurisdiction. Funding and supervision of children's placement should be provided by the Department of Social Services.

## APPENDIX D

## ORDER

State of Michigan
In The Circuit Court For The
County Of Wayne

At a session of said Court held in the City-County Building, City of Detroit, County of Wayne, Michigan, on the 26th day of February, 1974.

PRESENT: Honorable Victor J. Baum, Circuit Judge.

The parties hereto acting by their respective counsel, having consented to the entry of this order and having agreed as follows:

1. A complaint and other documents have been filed in this cause.

2. If true, the allegations could not be condoned under the Constitution of the United States, the Constitution of Michigan and the laws of this state.

NOW, THEREFORE, the parties by their respective counsel stipulate and agree as follows:

A. The State Department of Mental Health will immediately cease any and all experimentation, including experimental aversive conditioning, on children institutionalized in state mental health facilities, and will, in the future, no longer permit such experimentation or research, *such as the Zinc or C-14 Tryptophan studies at Lafayette Clinic, where the work has no basis in individual treatment of the physical illness of such child.*



B. The State Department of Mental Health will no longer permit experimental treatment to be used on any children institutionalized in a state mental health facility unless:

(1) the need for the use of experimental treatment arises out of a course of individual treatment of the physical illness of such child; and

(2) established therapies for the child's illness have been exhausted; and

(3) the consent of the child to the use of such experimental treatment has been obtained beforehand.

C. The State Department of Mental Health will not receive for detention and treatment any child unless and until a full judicial hearing has been held at which a legal determination has been made that such child is mentally ill, epileptic or handicapped as defined in Michigan law pursuant to constitutional requirements.

D. The State Department of Mental Health will petition or cause to be petitioned a court of competent jurisdiction for determination as to whether each child presently institutionalized in a state mental health facility is mentally ill, epileptic or handicapped. Unless such a determination has been made for each child within 150 days from the entry of this order, the State Department will return the care and custody of the child to the appropriate parent, guardian or custodian or if the parent, guardian or custodian is unable or declines to receive the child, then the department will cause a petition or other appropriate pleading to be filed with a court of competent jurisdiction (Circuit Court or Probate Court, Juvenile Division). The above time period shall be tolled during any period of adjournment which has been requested by the child's legal counsel. It is intended and hereby

provided that the foregoing is intended to deal with children in the care and custody of the State Department of Mental Health where such custody is not pursuant to hearing and court order. Nothing herein shall be taken to prevent Plaintiffs' representatives and counsel associated with them from providing legal assistance to a child within the scope of this order at the judicial review initiated by the aforementioned petitions.

E. The State Department of Mental Health will return to the care and custody of the appropriate parent, guardian or custodian any child who they are detaining and treating at a state mental health facility pursuant to an order of commitment, unless judicial review is afforded to such child at six month intervals from the date of the original commitment order. The purpose of this review, which is to be conducted in the same manner as the initial hearing described above, is to determine whether the child continues to meet the criteria for confinement and treatment at a state mental health facility.

F. The State Department of Mental Health will immediately make available for public inspection all proposals, protocols and other documents relating to experimentation or research being proposed or carried on in or for the department in state mental health facilities. This will not preclude any common law, statutory or constitutional defenses raised by any of the parties.

G. The State Department of Mental Health in or for the Department will immediately make available for inspection all individual consent forms after ensuring, through appropriate means, that the identity of individual subjects for experimentation is kept confidential. This will not preclude any common law, statutory or constitutional defenses raised by any of the parties.



H. The court reserves and retains jurisdiction of this cause to review and examine any action taken or not taken in implementation of this order and, upon due notice and hearing, to modify or alter this order to obtain compliance therewith.

I. The department and each of its divisions, institutions and its superintendents and each employee responsible for children who are institutionalized in mental health facilities shall receive a copy of the complaint (without documents) and a copy of this order no later than 30 days after its entry.

Circuit Judge (unsigned)

*Consent of Counsel*

The parties hereto, by their respective counsel, consent to the entry of the foregoing order and agree to the contents thereof.

FRANK J. KELLEY
Attorney General

/s/ Milton I. Firestone (P 13447)
Assistant Attorney General

/s/ Thomas R. Wheeker (P 22228)
Assistant Attorney General
740 Law Building
525 West Ottawa Street
Lansing, Michigan 48913

Dated: February 26, 1974

/s/ Clarice Jobes (P 15504)
Jobes, LeBost & Farrior, P.C.
408 Michigan Building
220 Bagley Avenue
Detroit, Michigan 48226
Petitioner and Attorney for
Petitioner-Plaintiffs

/s/ Gabe Kaimowitz (P 15654)
Michigan Legal Services
Assistance Program
Wayne State University Law School Annex
Detroit, Michigan 48202
Co-counsel for Petitioner-Plaintiffs

Dated: February 26, 1974

Annina Mitchell Dahm
Miriam Eichenhorn
Students at Wayne State University
School of Law
Practicing under GCR 921 for
Petitioner-Plaintiffs



## APPENDIX E

## LETTER OPINION

State of Michigan
Department of Attorney General

**Item B**
(Filed February 19, 1974)

Dr. E. G. Yudashkin, Director
Department of Mental Health
Lewis Cass Building
Lansing, Michigan 48926

Dear Dr. Yudashkin:

As you know, suit was filed earlier this month against the Department of Mental Health, yourself, as Department Director, and various physicians employed at the Lafayette Clinic.

That lawsuit raises three major issues concerning:

1. public access to information relating to experimentation conducted on mental patients in department institutions,

2. commitment procedures with regard to minors, and

3. consent to medical experimentation on minors in department institutions.

In view of the issues raised in this lawsuit, I would appreciate an immediate reply concerning the policy and procedure the Department of Mental Health and its facilities follow in each of these areas.

Meanwhile, I take this opportunity to advise you as follows:

1. Minors are, by law, committed to the Department of Mental Health for care and treatment of mental disorders. The department may not conduct experiments

on such minors unless the particular experiment contributes directly to the individual minor's care and treatment.

2. While the issue of what constitutes valid legal consent on the part of a child for experimentation has not been decided by a Michigan court, the decision of a three-judge panel in the recent case of *Doe* v. *Yudashkin* (the psychosurgery case) is instructive. In that case, the court ruled that an adult patient was not in a position to give truly voluntary consent to a dangerous procedure offering minimum, if any, benefits to that patient. In the case of a child, it would seem that the coercive atmosphere of a mental institution as was shown by testimony in the *Doe* case, combined with the youth of the potential experimental subject, would be such that a child could never be said to truly voluntarily consent to an experiment, particularly when it is unlikely that he would ever truly understand what he was consenting to.

Since the child could not consent, the experiment could not be conducted. While it is true that a parent can consent of behalf of a child to medical procedures which are necessary to preserve the health of the child, e.g., *Bakker* v. *Welsh*, 144 Mich 632 (1906), nationally, cases have held that this does not empower the parent to make his child a guinea pig. The parent has no authority to subject his child to medical procedures which are not designed primarily for the benefit of that child.

I also call your attention to the following statement set forth in the recently issued guideline of the Department of Health, Education and Welfare covering this subject:

> "There is no firm legal basis . . . for parental or guardian consent to participation in research on behalf of subjects who are incompetent, by virtue of age or mental state, to understand the information provided and to formulate the judgments on which valid consent must depend . . . ." Federal Register, Vol. 38, No. 221, Friday, 11/16/73, p. 31739



It is my feeling, based upon my study of current court decisions and applicable circumstances, that persons confined to institutions, particularly children, may not be able to give truly voluntary consent in such matters. It must also be recognized that persons encumbered with economic or custodial responsibility for the mentally infirm may not be sufficiently objective to make judgments which are fully in the best interest of the institutionalized person as it relates to research, development or demonstration activity.

It must also be kept in mind that despite all the protection afforded by various research committees certain children are categorically excluded from participating in research involving risk. These include children with no natural or adoptive parents available to participate in consent deliberations and children detained in department facilities by court order.

3. The Administrative Procedures Act's provision that a state agency shall make available for public inspection "written statements which implement . . . law, rules or policy, including . . . guidelines, mannuals and forms . . ." is applicable to the Department of Mental Health, provided the material involved is not covered by the doctor-patient exemption.

I urge you to make the foregoing available to all superintendents of all institutions subject to your jurisdiction at once.

Sincerely yours,

/s/ Frank J. Kelley,
Attorney General

## APPENDIX F

## LETTER OF THE CHAIRMAN

HOUSE OF REPRESENTATIVES
Lansing. Michigan 48901
Chairman; Judiciary Committee

July 15, 1976

MEMO TO: The Honorable Anthony Derezinski, The Honorable Thomas Anderson

FROM: Paul A. Rosenbaum, Chairman, House Judiciary Committee.

This will supplement my letter of July 9, 1976.

I wish to personally request that, if the Joint Administrative Rules Committee is going to initiate any or all of revised Rule 330.7021 of the Administrative Rules of the State Department of Mental Health, I wish to have an opportunity to personally appear in front of the Committee to testify on this issue.

Also, would you extend to me the courtesy of inviting Mr. Kaimowitz, of the Michigan Legal Services, to appear at the same time so that the Committee may be apprised of his comments as well as mine.

It is my understanding that the emergency rules presently in effect will remain in effect unless the Joint Administrative Rules Committee acts on the revised Rule 330.7021.

Thanking you in advance for your cooperation.

cc: Paul Tarr, Gabe Kaimowitz

PAR/sf



## APPENDIX G

## EMERGENCY RULE

**R 330.7021. Research or treatment procedures which place recipients at risk.**

Rule 7021. (1) A recipient shall not be the subject of a medical or social research or treatment procedure if the research or procedure places subject at risk, unless the requirements of this rule are met to insure the protection of the recipient.

(2) As used in this rule:

(a) "Subject at risk" means an individual who may be exposed to the possibility of injury, including physical, psychological, or social injury, as a consequence of participation as a subject in research or as a consequence of a treatment procedure which departs from application of established and accepted activities necessary to meet the individual's needs, or which increases the ordinary risks of daily life, including the recognized risks inherent in a chosen occupation or field of service.

(b) "Medical and social research or treatment procedures which place subjects at risk" include not yet accepted or established procedures accepted and established procedures used in a manner other than recommended or prescribed, behavior modification involving use of noxious or aversive stimuli, electric shock, lobotomy, or other psychosurgical procedures, and organ transplants or other surgical procedures which are of other than therapeutic benefit to the recipient.

(3) Research or procedures which place a subject at risk shall not be conducted or sponsored by a provider unless a committee established by the facility director has reviewed and approved the activity.

(4) A recipient shall be the subject of a medical or social research or treatment procedure which place him at risk only if he is 18 years of age or over and competent, with his express and informed consent, and with an opportunity for consultation with legal counsel and independent medical specialists. Proposed research or procedures meeting the definition in rule (2b) shall be reviewed and approved by the committee before consent is sought.

(5) Recipients whose freedom and rights are, or potentially are, subjected to limitation may not be subjects of research unless a proposed activity is related to the etiology, pathogenesis, prevention, diagnosis, or treatment of mental disability or retardation or the management, training, or rehabilitation of the mentally disabled or retarded and seeks information which cannot be obtained from subjects who are not recipients.

(6) A review committee shall:

(a) Determine whether subjects would be placed at risk, and, if risk is involved, whether:

(i) Risks are outweighed by the sum of the benefit to subjects and the importance of the knowledge to be gained and thereby warrant a decision to allow subjects to accept these risks.



## APPENDIX H

## ORDER APPOINTING NEXT FRIEND

United States District Court
Eastern District Of Michigan
Southern Division

JOHN (DOE)
a minor, by his next friend,
TOM WOJCIEHOWSKI, individually,
and on behalf of all other
minors similarly situated,
Plaintiff,

THE DIRECTOR OF THE MICHIGAN
DEPARTMENT OF MENTAL HEALTH,
in his official capacity, and
his successors, assignees, employees and agents;
VERNON STEHMAN;
WILLIAM KIRK;
HARVEY DAY,
in their official capacities as employees and
agents of YPSILANTI STATE HOSPITAL and
THE MICHIGAN DEPARTMENT OF
MENTAL HEALTH.

*v* Civil Action 75-72318

This action seeks to challenge the Formal Voluntary Admission provisions of the Michigan Mental Health Code, MSA §§14.800 (415) (420), insofar as these provisions permit the admission of minors into state mental facilities upon the application of their parents or guardians without a prior judicial finding that commitment is appropriate.

The named plaintiff was eleven years old at the time the complaint was filed on November 26, 1975. On December 10, 1975, a motion was filed requesting the appointment of TOM WOJCIEHOWSKI as next friend for the named minor plaintiff. The defendants and the parents of the minor plaintiff, who sought to intervene in the action, opposed the appointment of Mr. WOJCIEHOWSKI, and, indeed, objected to the maintenance of the action on behalf of the child at all. A hearing was held, at which counsel for the parties and for the proposed intervenors argued this question. The Court indicated its intention to permit intervention by the parents, but did not so order, because it did not believe such a step would be appropriate until a decision was rendered on the designation of a next friend.

Following the hearing the Court requested that the parties file briefs on the question of the appointment of a next friend and make suggestions regarding an appropriate person to be so appointed. Counsel for plaintiff, defendants, and intervenors have filed such briefs.

The position taken by the intervenors is essentially that the parents are the real representatives of the child and that the Court should appoint no one in their place. However, if the constitutional right of the minor plaintiff has been violated, it must be alleged to be through the joint action of the state and the parents. Where there is a potential conflict between the interests of parent and child, the Court may be required to appoint a next friend other than the parents. See *Saville* v. *Treadway*, No. 6969 (M.D. Tenn. March 8, 1974) (three-judge court) (Exhibit G, appendix to plaintiff's Memorandum).

The defendants argued that a "neutral" attorney be appointed next friend. No specific suggestions were made.



The Court has independently sought to locate an appropriate neutral person to serve as next friend for the minor named plaintiff; however, it has been unable to locate a suitable person.

At the hearing on plaintiff's motion, the Court indicated that it believed there might be conflict in the appointment of Mr. WOJCIEHOWSKI. This concern stemmed from the Court's impression that Mr. WOJCIEHOWSKI was still employed at that time by a state agency and was still in a position in which he had or in the future might have a professional responsibility for the care of the minor plaintiff. The Court believed that such a situation would result in a conflict in his two roles: in one role as a next friend challenging the statute requiring care while at the same time providing that care, and, further, that if he were the appropriate professional to be caring for the minor child that he should not cease to do so because of his other role as next friend. However, re-examination of the documents submitted with the motion indicates that Mr. WOJCIEHOWSKI has not only ceased to be employed at the Yorkwood Center of Ypsilanti State Hospital but is also no longer in contact with the minor plaintiff as a "big brother." These facts remove the conflict with which the Court was concerned.

Defendants have objected to the appointment of Mr. Wojciehowski or plaintiff's attorneys of the ground that they have an underlying desire to at tack the statute that might overcome their concern for the welfare of the particular named plaintiff. The Court believes that this objection is more applicable to the attorneys for plaintiff than to Mr. WOJCIEHOWSKI. His intial contact with

the child was as a group leader at the Yorkwood Center for Children at Ypsilanti State Hospital. He was the person designated by the child to receive a copy of the formal voluntary admission application. It was he who contacted the attorneys who filed this action. Insofar as defendant and intervenor's argument is that Mr. WOJCIEHOWSKI's institution of this suit indicate that he will not fairly represent the interests of the child, such an objection begs the question. Mr. WOJCIEHOWSKI has apparently made a judgment that the commencement of this action is in the best interests of the child. If the fact of having made such a judgment must be taken as disqualifying a prospective next friend, then any person seeking to bring an action as a next friend for a minor would be similarly disqualified. The Court sees no reason to believe that Mr. WOJCIEHOWSKI did not make a good-faith judgment that this action should be commenced or that he will not continue to exercise such judgment.

In view of these factors and the Court's inability to locate another suitable next friend, the Court's inability to locate another suitable next friend, the Court will appoint TOM WOJCIEHOWSKI next friend for the named minor plaintiff in this action.

Counsel for plaintiff stated that she was concerned that she have access to the named plaintiff and expressed the view that the parents of the child were inhibiting such access. The Court has been shown no purpose requiring such contact. Plaintiff's counsel have presented nothing that would show that any facts within the knowledge of this particular minor plaintiff will be of any importance to the determination of this suit. This action involves a



constitutional issue that relates to the statute's basic scheme, rather than to its particular application to this plaintiff. Indeed, plaintiff's counsel analogize this action to cases in which courts found no need to appoint next friends because the suits concerned "narrow legal issue[s]." Memorandum of Law in Support of the Appointment of a Counsel for Plaintiff or any other Suitable Person as Next Friend, at 10.

Accordingly, the Court will enter no order directing either the intervening parents or the defendants to permit Mr. WOJCIEHOWSKI, or counsel for plaintiff to have access to the minor child. If plaintiff's counsel become aware of any particular reason why such contact is necessary they may make a written application to the Court with notice to the other parties. The Court recognizes that this procedure may prevent Mr. WOJCIEHOWSKI from becoming aware of facts that might lead him to dismiss or otherwise alter the course of this action. However, the Court is of the opinion it is in the best interest of the child that contact between the next friend or plaintiff's attorneys and the minor is likely to cause conflict between them and the parents and parents and child that would not be beneficial to the child.

CORNELIA G. KENNEDY
United States District Judge

March 9, 1976
Detroit, Michigan

## APPENDIX I

## ORDER
## AMENDING TITLE OF CASE AND
## DIRECTING CLERK TO CORRECT COURT RECORDS

United States District Court
Eastern District Of Michigan
Southern Division

TOM WOJCIEHOWSKI,
Next friend of JOHN DOE, a minor, Plaintiff,

*v* No. 75-72318

THE DIRECTOR OF THE MICHIGAN
DEPARTMENT OF MENTAL HEALTH, Defendant.

This action was filed on behalf of an eleven year old child, seeking to challenge the Formal Voluntary Admission provisions of the Michigan Mental Health Code, MSA §§ 14.800 (415) to (420), insofar as that statute permits the commitment of minors to state institutions without a prior judicial finding that such commitment is appropriate.

In its Order entered March 9, 1976, the Court appointed TOM WOJCIEHOWSKI as next friend for the minor plaintiff. In view of this fact and the Court's opinion that it is desirable to minimize the public exposure of the particular minor plaintiff, the Court HEREBY ORDERS that THE TITLE OF THIS CASE BE AMENDED TO READ:

TOM WOJCIEHOWSKI,
Next friend of JOHN DOE, a minor,
on behalf of JOHN DOE and all
others similarly situated,
Plaintiff,



THE DIRECTOR OF THE MICHIGAN DEPARTMENT OF MENTAL HEALTH, in his official capacity; and his successors, assignees, employees and agents; VERNON STEHMAN; WILLIAM KIRK; and HARVEY DAY, in their official capacities as employees and agents of Ypsilanti State Hospital and The Michigan Department of Mental Health,

Defendants.

The parties are ORDERED to file all subsequent pleadings under this amended title, and the Office of the Clerk of the Court is DIRECTED TO CORRECT THE COURT RECORDS TO REFLECT THIS CHANGE OF TITLE.

IT IS SO ORDERED.

CORNELIA G. KENNEDY
United States District Judge

Dated: March 9, 1976
Detroit, Michigan

## APPENDIX J

## ORDER GRANTING MOTION TO INTERVENE AS PARTIES DEFENDANT

United States District Court
Eastern District Of Michigan
Southern Division

TOM WOJCIEHOWSKI,
Next friend of JOHN DOE, a minor, on behalf of JOHN DOE and all others similarly situated,
Plaintiff,

*v* Civil Action No. 75-72318

THE DIRECTOR OF THE MICHIGAN DEPARTMENT OF MENTAL HEALTH,
in his official capacity, and his successors, assignees, employees and agents; VERNON STEHMAN; WILLIAM KIRK; and HARVEY DAY, in their official capacities as employees and agents of Ypsilanti State Hospital and The Michigan Department of Mental Health,
Defendants.

This action was filed on behalf of an eleven year old child, seeking to challenge certain features of the Formal Voluntary Admission provisional of the Michigan Mental Health Code, MSA §§ 14.800 (415) to (420). On March 9, 1976 the Court appointed TOM WOJCIEHOWSKI as next friend for JOHN DOE, the minor plaintiff;

The parents of JOHN DOE filed a motion to Intervene as Defendants. At the hearing on December



15, 1975, the Court indicated its intention to grant the motion but deferred its ruling until it had rendered a decision regarding the appointment of a next friend;

Accordingly, the motion of the parents to intervene as parties defendant IS GRANTED. In keeping with the Court's ORDER AMENDING TITLE OF CASE AND DIRECTING CLERK TO CORRECT COURT RECORDS, also entered this date, March 9, 1976, the Court DIRECTS that the parties refer to the intervening defendants as Mr. and Mrs. DOE. IT IS SO ORDERED.

CORNELIA G. KENNEDY
United States District Judge

Dated: March 9, 1976
Detroit, Michigan

## APPENDIX K

## ORDER CERTIFYING THAT SUIT MAY PROCEED AS CLASS ACTION

United States District Court
Eastern District Of Michigan
Southern Division

TOM WOJCIEHOWSKI,
Next friend of JOHN DOE, a minor, on behalf of JOHN DOE and all others similarly situated,
Plaintiff,

*v* | Civil Action No. 75-72318

THE DIRECTOR OF THE MICHIGAN DEPARTMENT OF MENTAL HEALTH,
in his official capacity; and his successors, assignees, employees and agents; VERNON STEHMAN; WILLIAM KIRK; and HARVEY DAY, in their official capacities as employees and agents of Ypsilanti State Hospital and The Michigan Department of Mental Health,
Defendants.



This is an action in which plaintiff challenges the constitutionality of the Formal Voluntary Admission provisions of the Michigan Mental Health Code. MSA §§14.800 (415) to (420). Plaintiff has filed a Motion for Class Action Order, requesting that a class be certified consisting of:

> all persons under 18 years of age who have been, now are or will be admitted to hospitals under the Formal Voluntary Admission sections of the Michigan Mental Health Code, MCLA 330.1415-1420 [MSA §14.800 (415) to (420)].

The Court should order that the action may proceed as a class action only if all four of the requirements of Federal Rule of Civil Procedure 23(a) and at least one of the requirements of Rule 23(b) are met.

The state defendants do not dispute that the first two requirements of Rule 23(a) are met: that the proposed class would be too numerous to permit joinder of all, or that there is a common question of law. They do argue that the claims of the named plaintiff are not typical of those of the class and that plaintiff would not adequately represent the class.

In one sense, of course, the claims are clearly typical: insofar as any member of the proposed class has a claim, it is indistinguishable from that of the named plaintiff, since all members of the class would be denied the same constitutional right by the application of the statute.

Defendants' real position is that the relief sought by the named plaintiff would in fact be harmful to the members of the class, rather than beneficial. There is no factual basis for such a finding in the record. If one assumes for the purpose of argument that the statute is constitutionally defective, the fact that some persons might be satisfied with it would not deprive plaintiff of the right to declaratory and injunctive relief that would affect the entire class.

Defendants' argument in reality presents a question to be decided when the three-judge court considers the merits of the action. The fact that some members of the class may be satisfied with the treatment they receive is not grounds for refusing to certify a class. See *Norwalk Core* v. *Norwalk Redevelopment Agency*, 395 F. 2d 920, 937 (2d Cir. 1968). See also *Knuth* v. *Erie-Crawford Dairy Cooperative Association*, 395 F. 2d 420, 428 (3d Cir. 1968); *Lamb* v. *United Security Life Company*, 59 F.R.D. 25, 31-32 (E.D. (S.D. Iowa 1972).

The claim that this is an appropriate case for class certification is supported by the decisions of several three-judge district courts to permit class actions in very similar cases. See *Kidd* v *Schmidt*, No. 74-C-605 (E.D. Wisc., Aug. 15, 1975); *Bartley* v *Haverford State Hospital*, No. 72-2272 (E.D. Pa. April 29, 1974).

The fact that the named minor plaintiff may not be in Ypsilanti State Hospital continuously does not mean that he cannot represent the class, since he remains subject to readmission under the challenged portion of the statute. *Kidd* v. *Schmidt*, *supra*, at 3.

In regard to the question of whether the named plaintiff will adequately represent the class, there seems little doubt that plaintiff and counsel will vigorously prosecute this action. Indeed, part of the objection raised by defendants seems to be based on the defendants' concern that counsel will be too vigorous.

They argue that the relief requested by plaintiff would not be that sought by most of those in the class. The Court sees no basis on which it could find that the class members would not desire a remedy for a (presumed) violation of their right to due process of law. Defendants' position goes to the merits of the action which must be considered by the three-judge court, rather than by a single judge considering a motion for class certification.



The Court is of the opinion that the requirements of both Rule 23(b)(1) and 23(b)(2) are met, and defendants apparently do not disagree. What defendants do argue is that some notice should be given to the class members. As defendants recognize, the rule does not require notice. Fed. R. Civ. Pro. 23(c)(2). Defendants provide no authority for their assertion that due process requires notice of this action. See *Eisen* v. *Carlisle & Jacquelin*, 417 U. S. 156, 177 (1974).

Accordingly, the Court determines that this suit may appropriately proceed as a class action pursuant to Federal Rule of Civil Procedure 23, on behalf of all persons under 18 years of age who have been, now are or will be admitted to hospitals under the Formal Voluntary Admission provisions of the Michigan Healt. Code, MSA §§ 14.800(415) to (420).

IT IS SO ORDERED.

CORNELIA G. KENNEDY
United states District Judge

Dated: March 12, 1976
Detroit, Michigan

## APPENDIX L

## ORDER APPOINTING NEXT FRIEND

United States District Court
Eastern District of Michigan
Northern Division

As a session of said court, held in the Federal Building, Flint, Michigan on March 22nd, 1976

Present: HONORABLE JAMES HARVEY, United States District Judge

On November 28, 1975 plaintiff moved to appoint Mr. David Wineman as a substitute Next Friend, having determined that Mrs. Edna White was not a proper person to be so appointed.

Defendants filed their response in opposition to the motion to substitute next friend on December 12, 1975. The main objection to the proposed substitute Next Friend is that Mr. Wineman may have a personal interest in this action which is opposed to the interest of the plaintiff.

Having reviewed the above mentioned motion and the legal memoranda in support thereof and in opposition thereto, as well as the supporting documentation, records, and the sworn affidavits of the plaintiff and the proposed Next Friend, the Court finds the following:

1.) Plaintiff is a seventeen year old minor;

2.) The present Next Friend, Mrs. Edna White is unsuitable as a Next Friend for there may exist a conflict of interest;

3. Plaintiff has voluntarily chosen a substitute Next Friend by the name of David Wineman;



4.) Mr. David Wineman is a Professor of Social Work at Wayne State University who has had the occasion to meet and talk with the plaintiff;

5.) Mr. David Wineman is willing to act as Next Friend of the plaintiff Deborah White;

6.) There is no conflict of interest between the proposed substitute Next Friend and the plaintiff;

Based on the above findings, the Court concludes that Mr. David Wineman will adequately protect the minor plaintiff's interest in this action and therefore Mr. Wineman shall be appointed as the Next Friend of plaintiff in lieu of Mrs. Edna White, the present Next Friend.

Now, then, IT IS HEREBY ORDERED that the Motion to Appoint a Substitute Next Friend is GRANTED.

/s/ James Harvey
United States District Judge

## APPENDIX M

## ORDER DENYING CERTIFICATION OF SUIT AS CLASS ACTION

United States District Court
Eastern District of Michigan
Northern Division

At a session of said court, held in the Federal Building, Flint, Michigan on March 22nd, 1976

Present: HONORABLE JAMES HARVEY, United States District Judge.

On October 17, 1975 plaintiff filed a Motion for Class Action Order. Plaintiff asserts that this action is properly maintainable as a class action under Rule 23(a), 23(b)(1) and (b)(2) of the Federal Rules of Civel Procedure on behalf of all persons under eighteen years of age who have been, now are or will be admitted to hospitals under the Formal Voluntary Admission sections of the Michigan Mental Health Code, MCLA 330.1415-1420.

Defendants filed a brief in opposition to the Motion for Class Action Order on December 12, 1975.

Having reviewed the motion and briefs in support thereof and in opposition thereto, the Court finds that this action may be properly maintainable as a



class action with regard to the prayer for declaratory and injunctive relief only for those persons under eighteen years of age who have been, now are or will be admitted to hospitals under the Formal Voluntary Admissions sections of the Michigan Mental Health Code, MCLA 330.1415-1420. The above finding is in accord with the Court's ruling in the companion case of *Wojciehowski* v. *Michigan Dept. of Mental Health* (No. 75-72318, ED Mich March 12, 1976).

However, it is unnecessary at this time to certify this action as a class action since there has been such a certification in the companion case. The class as designated in Case No. 75-72318 encompasses the same members as contemplated in the instant motion. As a matter of fact and law the minor plaintiff in this case has become a member of the class designated in the companion case for there is no notice requirement to plaintiff to make her a member of the named class and plaintiff has not specifically opted out of class as designated. There can be no further purpose served by also certifying this action as a class action given the above circumstances.

Therefore, IT IS HEREBY ORDERED that the plaintiff's Motion for Class Action Order is DENIED.

/s/ James Harvey
United States District Judge

## APPENDIX N

## MEMORANDUM OPINION

United States District Court
Eastern District Of Michigan

This is a motion to dismiss which has been filed by five of the named defendants, all of whom are employees of the State of Michigan (hereinafter referred to as State defendants), pursuant to Rule 12(b)(1),F R Civ P. It is asserted that the Court lacks jurisdiction over the first of plaintiff's three causes of action.

The facts as they appear in the complaint are as follows. Prior to December 17, 1974, plaintiff was residing in the home of her mother-in-law, Edna White. On that date she was taken into custody by Saginaw Police officers, detained briefly at a police facility, and finally transported to Saginaw Community Hospital, all allegedly at the request of defendant Francis Cook. Defendant Cook, acting as a person *in loco parentis*, signed a Formal Voluntary Admission Application on December 18, 1974 which resulted in plaintiff's admission into the Adolescent Psychiatry Unit of the hospital. This procedure was carried out pursuant to Section 415 through 420 of the Michigan Mental Health Code (MCLA 330. 1415-1420; MSA 14.800 (415)-(420)). On January 2, 1975, Edna White contacted attorneys for Legal Services of Eastern Michigan and requested them to visit plaintiff at the hospital. Plaintiff told the attorneys that she was about to be taken to Odyssey House, a facility in the State of New York, and indicated that she did not wish to go there. She signed an affidavit at that time indicating her desire to be free of



confinement. Late in the afternoon of January 2, 1975, one of the attorneys informed defendant Cook, and defendants Monica Lasarge and Paul Chapman that plaintiff did not wish to be sent to New York. On January 3, 1975, plaintiff was sent by airplane to Odyssey House. Once there, certain events occurred which are not important to this motion. It should be noted however, that plaintiff gave birth to a child in March of 1975 while at Odyssey House, and subsequent to that time both she and her child have returned to Michigan. The Court is aware that plaintiff is not confined in any institution at the present time.

Plaintiff alleges three causes of action, the first of which is brought on her own behalf and on behalf of all other persons similarly situated pursuant to Rule 23(a), 23(b)(1) and (b)(2), F R Civ P. The class action has yet to be certified. In the first count, plaintiff alleges that she and other members of her class are currently subjected to incarceration or confinement under the Formal Voluntary Admission Section of the Michigan Mental Health Code, *supra* for indefinite lengths of time without judicial hearings prior to or simultaneous with their confinement to determine (a) whether they have formally volunteered for admission or (b) whether they are to be involuntarily held as persons who are mentally ill and requiring treatment. A cause of action is claimed under Title 42 USC 1983 for deprivation of civil rights by all the named State defendants, said deprivation being capable of complete remedy only by enjoining the enforcement of MCLA 330.1415-1420 and declaring them unconstitutional.

In Count II, plaintiff alleges a conspiracy under Title 42 USC 1985(3) on the part of the State defendants and Odyssey House defendants to deprive her of her rights to liberty under the equal protection of the law. Count III

alleges a deprivation of liberty also, and seeks damages in excess of $10,000.00 for the unconstitutional and unlawful acts of all defendants for subjecting plaintiff to false arrest, false imprisonment, unwanted treatment, illegal transportation across state lines, intentional infliction of emotional distress, assault and battery, and misrepresentation and fraud.

A separate prayer for relief asks that plaintiff's cause be set down for hearing before a three-judge court and that MCLA 330.1415-1420 be preliminarily and permanently enjoined and declared unconstitutional on behalf of plaintiff and her class. On behalf of herself, plaintiff seeks $250,000.00 in damages against all defendants, jointly and severally.

28 USC 2281 provides that an injunction restraining the enforcement, operation or execution of any State statute may not be granted by a District Judge upon the ground of unconstitutionality of such statute unless the application therefor is heard and determined by a three-judge court as provided for by 28 USC 2284. Plaintiff has requested that a three-judge court be impaneled to hear her request for a preliminary and permanent injunction of the enforcement of MCLA 330.1415-1420. Oral arguments were heard regarding the request, which are at this time under advisement due to the intervention of several motions to dismiss filed by various defendants.

The State defendants have pointed out to the Court that when plaintiff left Saginaw County Community Hospital, she was discharged from that hospital. She was not admitted to Odyssey House pursuant to any provision of the Michigan Mental Health Code. Plaintiff is alleged to be a state ward and was placed in Odyssey House



pursuant to the authority of the Michigan Department of Social Services to control and care for state wards. Because plaintiff was not subject to any provision of the Michigan Mental Health Code for some time prior to the institution of this suit, nor having been so subjected since then, it is defendants' contention that "declarative and injunctive relief as to the constitutionality on the Michigan Mental Health Code can have no effect of plaintiff . . . any declaratory relief granted by this Court would be strictly an advisory opinion on a dead set of facts." (p. 5, defendants' brief) It is on this basis that dismissal of Count I is sought.

In order for a Federal Court to entertain a declaratory judgment action the complaint must set forth a live, actual controversy and not a moot, abstract or hypothetical one. *Aetna Life Ins. Co.* v. *Haworth*, 300 US 227 (1937); *Golden* v. *Zwickler*, 394 US 103 (1969). If plaintiff's request for declaratory and injunctive relief is in fact moot then there is no substantial federal question raised, there is no need to convene a three-judge court, and the defendants' motion to dismiss must be granted.

Plaintiff argues that there is a justiceable controversy between her and the State defendants for several reasons. First, it is contended that even if there is no live claim for injunctive relief, plaintiff's claim for damages is still alive and affords a basis for jurisdiction. Second, it is argued that this case falls within the rule that cases will not be mooted where they are capable of repetition yet evade review. Third, plaintiff believes this case to present a controversy over the continuing effects of defendants' past unlawful actions — the stigma of commitment.

Plaintiff's first cause of action clearly does not seek damages. That count is brought on behalf of plaintiff and the class she purports to represent and seeks declaratory and injunctive relief. While the count indicates plaintiff's belief that the portions of the Michigan Mental Health Code under which she was confined at the Saginaw County Community Hospital are unconstitutional, it is in Count III that plaintiff seeks damages for that confinement on her own behalf. There she characterizes the confinement under various common law torts such as false arrest and imprisonment. However, plaintiff characterizes her confinement as being unconstitutional. Thus Count III is also seen as seeking damages under 42 USC 1983.

Plaintiff notes that damages are proper relief in a 1983 action, and that even if she has no live claim for injunctive relief, the dispute over damages renders her cause justiceable. *Powell* v *McCormack*, 395 US 486 (1969). Defendants appear not to dispute this. In fact, they do not seek dismissal of plaintiff's second and third counts. The Courts agree with plaintiff that the dispute over damages is contested vigorously by the parties at this time. If plaintiff was illegally confined, there is no doubt but that a claim for damages is proper and not mooted by the fact that she is no longer confined.

*Powell* v. *McCormack*, *supra*, recognized that a damage claim may have at its foundation a claim that the defendants' initial actions were unconstitutional, and that declaratory relief is therefore proper and necessary to the ultimate disposition of damages. *Powell* was, in fact,



remanded to the District Court with instructions to enter a declaratory judgment in conjunction with Powell's claim for back salary. In the present case, a similar situation exists. Plaintiff cannot collect damages for her confinement unless it is shown that that confinement was pursuant to an unconstitutional statute. Thus plaintiff's request for declaratory relief is properly pleaded. See also *Super Tire Engineering Co.* v. *McCorkle*, 416 US 115 (1974); *Bosely* v. *City of Euclid*, 496 F2d 193 (CA 6 1974).

The next question is whether plaintiff properly requests injunctive relief. A related issue is whether a three-judge court is required if this Court finds that it has no jurisdiction over plaintiff's claim for injunctive relief. This Court can construe the constitutionality of the challenged sections of the Michigan Mental Health Code but may not, by itself, enjoin their enforcement by a State official. If the Code was found to be constitutional, there would be no need for an injunction; if not so found, then plaintiff could request further injunctive relief. See *Powell* v. *McCormack*, *supra*, p. 499.

If it is demonstrated that plaintiff's claim for injunctive relief is not a live controversy such as to give this Court jurisdiction over it, then plaintiff is left to her declaratory relief and damages. No three-judge court need be impaneled. Further, defendants' motion to dismiss would be proper as to the injunctive claim found in Count I. Plaintiff attempts to avoid this result by arguing that, while she is no longer confined, she is capable of again being subjected to confinement. It is urged that this case falls within the "capable of repetition yet evading review" doctrine. *Southern Pacific Terminal Co.* v. *ICC*, 219 US 498 (1911).

There is no doubt that admission to and confinement in a State Mental Institution is an example of "governmental action directly affecting, and continuing to affect, the behavior of citizens in our society." *Super Tire Engineering Co.* v. *McCorkle, supra*, p. 126. Plaintiff has shown that she was admitted to a mental institution upon the signature of an employee of the Michigan Department of Social Services. Assuming that plaintiff is a ward of the State and considering that she will be until she reaches the age of eighteen, her claim that she may again be signed into a mental hospital is not without foundation. It cannot be said at this time that it is a certainty that she will never again be subjected to the acts which she has complained of. Her first stay lasted for two weeks, which is barely enough time to start a lawsuit. A future stay may be for a similarly short period of time. As noted in *Medynski* v. *Margolis*, 389 F Supp 743,745 (DC 1975), "Inherent in mental health proceedings is the occurrence of short-term detention and/or confinement." Plaintiff has shown the existence of an immediate and governmental policy that has been brought to bear upon her interests to liberty and which remain available to affect those interests at any time. She has shown that policy to be one which can be so quickly exercised, and its effects so quickly subject to termination by actions of the State, that successful legal action will remain frustrated unless this case is seen to fall within the "capable of repetition, yet evading review" exception to the mootness doctrine.

Therefore, plaintiff's request for injunctive relief is not moot, and her first cause of action should not be dismissed. Plaintiff has raised various other contentions



in support of her opposition to the State defendants' motion. It is not necessary to examine those arguments in view of the conclusions which have been reached on what the Court believes to be the primary grounds for finding that a genuine controversy exists on all of plaintiff's causes of action.

Defendants Donald Smith, John Dempsey and Ernest Smith have filed a separate motion to dismiss in which they allege that the references to them in the complaint are so lacking in substance as to fail to state a claim against them. It is urged that they be dismissed pursuant to Rule 12(b)(6), F R Civ. P.

Defendants Smith, Dempsey and Smith are identified in paragraphs 8, 9 and 13 of the complaint as follows:

> "8. Defendant Director of the Michigan Department of Mental Health has the administrative responsibility for implementing and enforcing the Michigan Mental Health Code; said code includes the statutes in question herein, MCLA 330.1415-1420, which authorize the formal voluntary admission of persons under 18 years of age into hospitals for inpatient treatment as mentally ill persons."
>
> "9. Defendant Director of the Michigan Department of Social Services is responsible for all actions and operations of said Department, its employees and agents, as provided in MCLA 400, *et seq.*, including the administration of all public assistance programs and supervision of the actions of the local county departments when implementing programs that are in effect statewide. R. Bernard Houston is currently the Director of said Department; he is to be succeeded by John Dempsey on April 1, 1975."

> "13. Defendant Ernest Smith is the Director of the Saginaw County Department of Social Services and in that capacity is responsible to the United States and the State of Michigan for the implementation, administration and operation of all public assistance programs in Saginaw County, Michigan."

The standard for judging the sufficiency of a complaint is quite broad. Before a complaint will be dismissed, it must appear beyond a doubt that plaintiff can prove no set of facts in support of her claims which would entitle her to relief against these three defendants. See *Conley* v. *Gibson*, 355 US 41 (1957).

Under the above guidelines, it is clear that plaintiff has alleged sufficient facts to state a cause of action against each of the three defendants in question. First, with regard to defendant Donald Smith, plaintiff has specifically stated that he is responsible for implementation and operation of the Michigan Mental Health Code including that section at issue herein, MCLA 1415-1420. Thus, defendant Donald Smith has direct control over the operation of said statutes including their use to commit plaintiff herein to defendant hospital. In fact, Donald Smith's control is such that pursuant to MCLA 330.1404, he is responsible for "prescribing the forms to be used" under the Mental Health Code. It is undisputed that plaintiff's commitment was executed pursuant to the forms and instructions provided by defendant Donald Smith. Therefore, said defendant is intimately involved with actions being complained of in this case.

Defendant John Dempsey is directly involved with the dispute herein. As Director of the Department of Social Services, he is alleged to be charged with the care, control and custody of wards of the State. Defendant



State officials have themselves maintained that plaintiff is a ward of the State. Defendant Dempsey's authority, if any, is to provide the necessary and proper treatment of delinquent and neglected minors assigned to him, MCLA 400.115. In essence, the issue herein revolves around the decisions made by defendant Dempsey and others for the treatment of plaintiff and their alleged violation of her constitutional rights by their actions.

Similarly, defendant Ernest Smith, as Director of the Saginaw County Department of Social Services, is alleged to be directly involved in the care, treatment and decisions of State wards placed in his immediate custody. Plaintiff feels that upon discovery in this action, she may be able to demonstrate even greater personal involvement of Ernest Smith in the actions complained of herein. The Court notes that in plaintiff's third cause of action and in her prayer for relief, she has stated a cause of action in tort against defendant Ernest Smith. Therefore, defendant's motion will be denied.

Since plaintiff has demonstrated that an actual live controversy exists between her and the State defendants, and because she has demonstrated that substantial constitutional questions are involved in the claims which she asserts, this Court believes that a three-judge district court should be convened. An appropriate order will be signed.

/s/ James Harvey
United States District Judge

Dated: August 6, 1975

Supreme Court, U. S.
FILED
AUG 4 1976
MICHAEL RODAK, JR., CLERK

IN THE

# Supreme Court of the United States

OCTOBER TERM, 1976

**No. 75-1064**

JACK B. KREMENS, *et al., Appellants*

v.

KEVIN BARTLEY, *et al., Appellees*

**On Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania**

## BRIEF OF AMERICAN PSYCHIATRIC ASSOCIATION, AMERICAN SOCIETY FOR ADOLESCENT PSYCHIATRY, AMERICAN ACADEMY OF CHILD PSYCHIATRY, AND AMERICAN ASSOCIATION OF PSYCHIATRIC SERVICES FOR CHILDREN, AS AMICI CURIAE

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IN THE

# Supreme Court of the United States

OCTOBER TERM, 1976

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No. 75-1064

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JACK B. KREMENS, *et al., Appellants*

v.

KEVIN BARTLEY, *et al., Appellees*

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**On Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania**

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## BRIEF OF AMERICAN PSYCHIATRIC ASSOCIATION, AMERICAN SOCIETY FOR ADOLESCENT PSYCHIATRY, AMERICAN ACADEMY OF CHILD PSYCHIATRY, AND AMERICAN ASSOCIATION OF PSYCHIATRIC SERVICES FOR CHILDREN, AS AMICI CURIAE

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### INTEREST OF AMICI CURIAE

The American Psychiatric Association (A.P.A.), founded in 1844, is the nation's largest organization of qualified doctors of medicine who specialize in psychiatry. Over 21,000 of the nation's approximately 25,000 psychiatrists are members of the Association. The A.P.A. has participated as an amicus curiae numerous times in cases throughout the country involving mental health issues.

The American Society for Adolescent Psychiatry is a nationwide organization of approximately 1,200 doctors of medicine who specialize in the practice of adolescent psychiatry. The American Academy of Child Psychiatry is a nationwide organization of approximately 1,600 doctors of medicine who specialize in the practice of child psychiatry. The American Association of Psychiatric Services for Children is a national multi-disciplinary organization of child mental health agencies and professionals, whose membership includes 175 separate agencies with total staffs of approximately 10,000 people.

Amici believe this case to be of great significance to the quality of care available to mentally ill and mentally retarded children. The landmark ruling below that parents may not obtain even short-term residential psychiatric care for such children without judicial intervention is of immense concern to members of amici and to their patients.

## CONSENT OF THE PARTIES

Amici are filing this Brief with the consent of both parties, whose letters of consent have been filed with the Clerk.

## STATEMENT OF THE CASE

This case is here on appeal from the decision of a three-judge United States District Court for the Eastern District of Pennsylvania granting broad declaratory and injunctive relief against the continued enforcement of Sections 402 and 403 of Pennsylvania's Mental Health and Mental Retardation Act of 1966.

The named plaintiffs in this class action are juveniles who were admitted to a Pennsylvania state hospital



by their parents pursuant to the above provisions of Pennsylvania law. App. 788a-89a. The named plaintiffs ranged in age from 14 to 17 at the time of their hospitalization and purport to represent all persons 18 years of age or younger who have been, are, or may be admitted to mental health facilities in Pennsylvania under Sections 402 and 403. App. 783a, 789a. Plaintiffs sought an order declaring these provisions of state law unconstitutional as violating plaintiffs' rights to procedural due process under the Fourteenth Amendment to the United States Constitution, and they sought injunctive relief against continued enforcement of these provisions by defendant state officials.

The statute at issue here and its implementing regulations allowed[1] parents to place their mentally ill or mentally retarded child in a mental health facility if the parents' conclusion that the child's best interests require residential care was confirmed by the written opinion of a referring psychiatrist (or a medical or psychological opinion in the case of a retarded child) *and* by an independent examination of the child to be conducted by the director of the proposed institution, or his delegate. Children 13 years of age or older received notice that they had a right to obtain appointed counsel and to object to remaining in the institution. Any objecting child would be released within two business days unless an involuntary commitment proceeding was initiated. App. 815a-16a.

The district court, one judge dissenting, held that Sections 402 and 403 violated plaintiffs' rights because these provisions allowed parents to admit their children to mental health institutions without granting the children certain enumerated elements of procedural

[1] A new state statute recently repealed many provisions of the law reviewed by the court below. *See* Section I, *infra*.

due process. The court ordered that henceforth all children admitted to Pennsylvania mental health institutions must have counsel appointed for them and receive written notice that a "probable cause hearing" will be held within 72 hours of hospitalization. In addition, a full "post-commitment hearing" must be held within two weeks of hospitalization. At both such hearings the court ordered that the child and counsel shall have the right to be present, cross-examine witnesses and present testimony in order to challenge before an impartial tribunal the propriety of the parents' and admitting psychiatrists' judgment that the child needs residential care. The court also ordered that within 120 days of the effective date of its Order each of the thousands of children hospitalized in state mental health facilities must be either discharged or recommitted under the court-imposed procedures. App. 843a-52a.

This Court on December 16, 1975, granted a stay of the district court's Order, and on March 22, 1976, noted probable jurisdiction over this appeal.

## SUMMARY OF ARGUMENT

This case presents novel and difficult questions concerning the proper procedures for parents and guardians to follow when residential psychiatric care is medically recommended for their children. The issues are complex, because resolution of these procedural questions will have a profound impact on other competing rights and interests of both the children and their parents.

This Court has emphasized repeatedly that parents have a basic constitutional right and responsibility to control the upbringing of their children. *See, e.g., Wis-*



*consin* v. *Yoder,* 406 U.S. 205, 232 (1972); *Pierce* v. *Society of Sisters,* 268 U.S. 510, 534-35 (1925). This right is not without limitations, *see Planned Parenthood* v. *Danforth,* 44 U.S.L.W. 5197, 5203-04 (U.S., July 1, 1976); *Prince* v. *Massachusetts,* 321 U.S. 158, 166 (1944), but, absent extraordinary circumstances, it should be controlling in view of the fundamental legal and societal interest in preserving the integrity and autonomy of the family unit. The lower court not only failed to give any consideration to this principle of parental rights and duties, but it also ignored the fact that in certain categories of mental health admissions the legal imposition of adversary hearing procedures will prove therapeutically counter-productive for the child, because of the very delicate emotional problems present in such parent-child conflicts.

The decision below applies the deceptively simple syllogistic reasoning that children's interest in avoiding admission to residential psychiatric care is a protected interest within the meaning of the Fourteenth Amendment's Due Process Clause, and therefore that all the traditional elements of procedural due process must apply to all these cases. Such an approach should have been the beginning, not the end, of the analysis, however.

Once it is determined that due process applies, the courts must still undertake the separate and highly subtle determination of what process is due. *Goss* v. *Lopez,* 419 U.S. 565, 577 (1975); *Morrissey* v. *Brewer,* 408 U.S. 471, 481 (1972). Due process is a flexible concept, and its elements must be decided in each situation with full regard for the competing interests and practical consequences of applying them. *Wolff* v. *McDonnell,* 418 U.S. 539, 563, 567 (1974).

The district court did not undertake such an analysis, but instead tried to fit these diverse cases into a rigid due process model to which they do not conform. The court ignored the fact that the class of plaintiffs varies dramatically with regard to the factors most relevant to the effect of the proposed procedures on the rights of children and their parents. The court ignored the very real harms that formal adversary hearing procedures can create in certain categories of cases.

Amici recognize that there are serious flaws in our nation's system of mental health care for children. These problems may be exacerbated, rather than alleviated, however, by the decision below. Amici believe that there are well-defined categories of cases in which *carefully crafted* hearing procedures may be appropriate and helpful. In other situations, which we describe in Section III, below, the potential harm of such procedures far outweighs any possible value, and thus both law and logic demand that they be excepted from any constitutionally imposed rule.

Amici contend that balancing the competing interests—in terms both of constitutional rights and of mental health concerns—should lead the courts to except from formal hearing requirements those cases in which 1) a parent in an intact family wishes to admit a 2) pre-adolescent child 3) to an accredited institution 4) for a short-term period (*e.g.*, less than 45 days). We will set forth below why we believe this to be the most appropriate resolution of these important and difficult issues.

## ARGUMENT

### I. ON JULY 9, 1976, PENNSYLVANIA ENACTED A NEW STATUTE GOVERNING THE ADMISSION OF MENTALLY ILL CHILDREN.

At the outset, Amici must bring to the Court's attention the very recent passage of a new Pennsylvania law



governing the procedures for admission of children to state mental health institutions. Signed into law by the Governor on July 9, 1976, the Mental Health Procedures Act, Pa. Act No. 143 ("Act"), completely repeals, "except in so far as they relate to mental retardation," the provisions of state law declared unconstitutional by the court below. *Id.*, § 502. Thus, while the state procedures reviewed by the lower court continue to apply to the admission of mentally *retarded* children to state institutions, the prior procedures for mentally *ill* children have been repealed and replaced by the provisions of the new Act.

Under this new state law, children who are 14 years of age or older have essentially the same rights concerning voluntary or involuntary admission to treatment as do adults. *Id.*, § 201.[2] Children less than 14 years of age may be admitted for treatment by a parent, although "any responsible party" may petition the court to withdraw the child from such treatment. *Id.*, §§ 201, 206(b). The new state statute makes many other changes in the state law under consideration here, including a requirement that each person admitted to state mental institutions has a statutory right to an individualized treatment plan that will afford the patient "adequate treatment for his condition," *id.*, §§ 104, 107, and that every patient "shall be examined by a treatment team and his treatment plan reviewed not less than once every 30 days." *Id.*, § 108. Such reexamination and review must ensure that each patient "shall not remain in treatment or under any particular

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[2] The only exception is that if a child over 14 admits himself or herself voluntarily, the child's parents may petition the court to have the treatment terminated and the child returned home. Act, § 204.

mode of treatment for longer than such treatment is necessary and appropriate to his needs." *Id.*, § 108(b). Amici recognize that this Court may conclude that it would be appropriate to vacate the decision below and remand this case for an initial interpretation of the extent to which this new state law departs from the prior statutory procedures reviewed by the court below. *See, e.g., Fusari* v. *Steinberg,* 419 U.S. 379 (1975).

Nevertheless, since counsel for Appellants and Appellees have informed Amici that they do not intend to suggest to the Court that it should remand this case for reconsideration in light of the new statute, and since the Court might conclude that certain aspects of the decision below raise recurring questions not rendered moot by passage of the new legislation, Amici will proceed in this Brief to set forth the considerations which we believe should govern if this Court reviews the merits of the decision below.

### II. THE LOWER COURT FAILED TO TAKE INTO ACCOUNT THE ESSENTIAL RESPONSIBILITIES AND RIGHTS OF PARENTS FOR THE UPBRINGING OF THEIR CHILDREN, AND THE POSSIBLE HARMS INVOLVED IN REQUIRING DUE PROCESS ADVERSARY HEARINGS IN ALL CASES.

As professional organizations whose members are devoted to assuring the highest quality of mental health care, Amici share the concern of plaintiffs and the court below that children all too often are admitted to mental health institutions that are not appropriate for their needs, or are allowed to remain in institutions far longer than medically desirable. In seeking to cure this problem, however, the district court attempted to fit this case into a traditional due process mold to which it does not easily conform. The lower court has promulgated a rigid constitutional rule that not only ignores the very important responsibilities and rights



of parents to control the upbringing of their children, but also disregards the clinical realities which suggest that in some cases due process hearings in fact may prove harmful to the child's best interests.

The district court cited cases such as *Wolff* v. *McDonnell,* 418 U.S. 539 (1974), and *Goss* v. *Lopez,* 419 U.S. 565 (1975), for the proposition that plaintiffs in this case have a liberty interest within the contemplation of the Fourteenth Amendment Due Process Clause. However, that should have been the beginning, not the end, of the analysis. "Once it is determined that due process applies, the question remains what process is due." *Goss* v. *Lopez,* 419 U.S. 565, 577 (1975); *Morrissey* v. *Brewer,* 408 U.S. 471, 481 (1972).

This Court has repeatedly emphasized that due process is a flexible concept which must vary according to the particular circumstances and competing interests involved in a specific situation. *Morrissey* v. *Brewer, supra,* 408 U.S. at 481. "[T]he interpretation and application of the Due Process Clause are intensely practical matters," *Goss* v. *Lopez, supra,* 419 U.S. at 578, and "[t]he very nature of due process negates any concept of inflexible procedures universally applicable to every imaginable situation." *Wolff* v. *McDonnell,* 418 U.S. 539, 560 (1974); *Cafeteria & Rest. Workers Union* v. *McElroy,* 367 U.S. 886, 895 (1961). Due process "is not a technical conception with a fixed content unrelated to time, place and circumstances." *Id.* "[N]ot all situations calling for procedural safeguards call for the same kind of procedure." *Morrissey* v. *Brewer, supra,* 418 U.S. at 481.

In the instant case, Amici believe that the lower court failed to take into account two fundamental factors that must be considered in any analysis of what process

is due when parents seek to admit their child to a mental health institution: (1) the parents' independent constitutional right and responsibility to control the upbringing of their child; and (2) the severe harms that can be caused in certain situations by application of a traditional due process hearing procedure—which was designed for conflicts between the state and an individual—to the very different, and emotion-laden situations that arise when the essential conflict appears to be between parent and child. Amici contend that a review of those factors should lead this Court to conclude that due process hearing procedures are appropriate in certain categories of children's mental health admissions, but that the court below has failed to craft its remedy with due consideration to the important and sometimes competing interests at stake in different categories of cases covered by this litigation.

### A. Parents Have a Basic Constitutional Right To Control the Upbringing of Their Children

This Court has repeatedly emphasized the long-recognized right of parents to control the upbringing of their children.

More than fifty years ago, in *Meyer* v. *Nebraska,* 262 U.S. 390, 399 (1923), the Court included within those liberties protected by the Fourteenth Amendment the basic right to "bring up children." The Court later cited the *Meyer* decision in *Pierce* v. *Society of Sisters,* 268 U.S. 510 (1925), declaring unconstitutional a state law that required parents of children between eight and sixteen years of age to send their children to public, rather than private, school. The Court held that it was "entirely plain that the [statute] unreasonably interferes with the liberty of parents and guardians



to direct the upbringing and education of children under their control." *Id.* at 534-35. Parents' authority to control the upbringing of their children is "basic in the structure of our society." *Ginsberg* v. *New York,* 390 U.S. 629, 639 (1968).

In *Wisconsin* v. *Yoder,* 406 U.S. 205, 232 (1972), the Court emphasized the "primary role of the parents in the upbringing of their children":

> The history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children. This primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition.

*See also Prince* v. *Massachusetts,* 321 U.S. 158, 166 (1944) (recognizing existence of "the private realm of family life which the state cannot enter"); *Stanley* v. *Illinois,* 405 U.S. 645, 651 (1972):

> The Court has frequently emphasized the importance of the family. The rights to conceive and to raise one's children have been deemed "essential," *Meyer* v. *Nebraska,* 262 U.S. 390, 399 (1923), "basic civil rights of man," *Skinner* v. *Oklahoma,* 316 U.S. 535, 541 (1942), and "[r]ights far more precious . . . than property rights," *May* v. *Anderson,* 345 U.S. 528, 533 (1953). "It is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder." *Prince* v. *Massachusetts,* 321 U.S. 158, 166 (1944). The integrity of the family unit has found protection in the Due Process Clause of the Fourteenth Amendment, *Meyer* v. *Nebraska, supra,* at 399, the Equal Protection Clause of the Fourteenth Amendment, *Skinner* v. *Oklahoma, supra,* at 541, and the Ninth

Amendment, *Griswold* v. *Connecticut,* 381 U.S. 479, 496 (1965) (Goldberg, J., concurring).

Finally, in *Runyon* v. *McCrary,* 44 U.S.L.W. 5034, 5039-40 (U.S., June 25, 1976), this Court reviewed the authorities discussed above and concluded that the parental rights recognized by cases such as *Meyer, Pierce,* and *Yoder,* and the familial privacy rights recognized in cases such as *Roe* v. *Wade,* 410 U.S. 113 (1973), and *Griswold* v. *Connecticut,* 381 U.S. 479 (1965), "may be no more than verbal variations of a single constitutional right." *Runyon* v. *McCrary, supra,* 44 U.S.L.W. at 5040 n. 15.

These parental rights are not, of course, without limitations. *See Prince* v. *Massachusetts,* 321 U.S. 158, 166 (1944). While parents generally have the right to give or withhold consent for most surgical procedures for their children, *see Bonner* v. *Moran,* 126 F.2d 121 (D.C. Cir. 1941); *Scaria* v. *St. Paul Fire & Marine Ins. Co.,* 68 Wisc. 2d 1, 227 N.W.2d 647 (1975), courts have overruled parents' religious objections and ordered blood transfusions that were necessary to save the child's life. *See, e.g., People* v. *Labrenz,* 411 Ill. 618, 104 N.E.2d 769 (1952); *Muhlenberg Hosp.* v. *Patterson,* 128 N.J. Super. 498, 320 A.2d 518 (1974).[3] However, such interference with parental discretion has been rare and is generally limited to instances where a child is in danger of suffering grievous harm. *See Muhlenberg Hosp.* v. *Patterson, supra,* 320 A.2d at

[3] *See generally* Annotation, *Power of Court Or Other Public Agency To Order Medical Treatment Over Parental Religious Objections for Child Whose Life Is Not Immediately Endangered,* 52 A.L.R.3d 1118 (1973); Annotation, *Power of Public Authorities To Order Medical Care for a Child Over Objection of Parent or Custodian,* 30 A.L.R.2d 1138 (1953).



521; Note, *State Intrusion into Family Affairs: Justifications and Limitations,* 26 STAN. L. REV. 1383, 1398-99 (1974) (standard is one of "severity and irreversibility" of harm to child); Note, *Child Neglect: Due Process for the Parent,* 70 COL. L. REV. 465, 472 (1970) ("the state should not be permitted to take this drastic step [intervening in parental decisions] without demonstrating that the child has been inflicted or threatened with serious harm"). *Compare In re Green,* 448 Pa. 338, 292 A.2d 387, 392 (1972) (state interest in child's health outweighs parents' religious belief only when child's life immediately imperiled), *with In re Seiferth,* 309 N.Y.2d 80, 127 N.E.2d 820, 137 N.Y.S.2d 35 (1955) (upholding parental refusal to allow operation to correct cleft palate); *In re Hudson,* 13 Wash. 2d 673, 126 P.2d 765 (1942) (upholding parent's refusal to permit removal of daughter's grossly deformed arm, although condition would result in permanent psychological and circulatory damage).

Similarly, in *Planned Parenthood* v. *Danforth,* 44 U.S.L.W. 5197 (U.S., July 1, 1976), the Court determined that a minor female's privacy right to determine whether or not to terminate her pregnancy outweighs the parents' right to control the child's actions by refusing to consent to an abortion. *Id.* at 5204. It is important to emphasize, however, that the Court reached that decision only *after* reviewing cases such as *Meyer, Pierce,* and *Yoder,* and concluding that the constitutional right of parental discretion and family integrity established by those cases was outweighed by the child's interest in this particular situation. *Id.* at 5203-04.

With the rare exceptions reviewed above, governmental respect for parental decision-making is essential to preserving the integrity of family life. Under

our social and legal system it is the parents who necessarily must assume responsibility for the myriad of difficult decisions concerning the health and welfare of their children. Indeed, parents who fail to do so may be guilty of neglect. A basic corollary of that responsibility or duty is the right to make those decisions free from unreasonable outside interference. *See* Kleinfeld, *Balance of Power Among Infants, Their Parents and the State,* 4 FAM. L.Q. 409, 413 (1970). *See also* Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions,* 62 CAL. L. REV. 840, 852 (1974) (juvenile commitment laws "have as their paramount objective the maintenance of family autonomy in dealing with aberrational behavior within the family"). Indeed, day in and day out, parents are called upon to make decisions of vital significance to the child's "liberty" or "property" interests—should the child be sent to a boarding school, have a tonsillectomy, study Latin, get braces? Even when the state is involved in such decisions,[4] however, it is seldom suggested that the child should have a right to receive a lawyer and a hearing to review each such parental determination. The reason is clear: parents' interest in preserving their authority and exercising their independent responsibility normally outweighs the child's interest in a legal procedure to question each such decision.

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[4] Frequently, some state action will be involved in such decisions—for example, through state educational or medical institutions. However, it should be noted that many parental decisions affecting the "liberty" of their children do not involve any state action. Indeed, parents frequently seek psychiatric care (as well as other forms of medical treatment) for their children from *private* physicians or residential facilities. A judicial ruling requiring due process hearings in all such situations, absent any state regulation or participation, would be inappropriate. *See generally Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345 (1974).



**In determining what procedures should be required by the due process clause when parents seek to admit their child to residential psychiatric care, the court below erred by failing to give any consideration at all to the parents' independent constitutional right and responsibility to control the care and upbringing of their children.**

### B. A Blanket Rule Requiring Immediate Due Process Hearings in All Cases Would Result Frequently in Psychological Harm to the Children.

**Another factor which the lower court unfortunately failed to take into account in determining what process is due before parents can admit their child for residential psychiatric care is the very real danger that because of the unique, emotion-laden situation created by these parent-child conflicts, a traditional due process hearing procedure poses severe risks, in certain cases, of psychological harm to the children whom the court was seeking to protect.**

**It is dangerously easy for courts to assume that the procedural model mandated for juvenile delinquency hearings, *see In re Gault,* 387 U.S. 1 (1967), can be adapted with little modification to psychiatric admission cases. From a clinical standpoint, however, this is highly improper. Indeed, if the procedural rights granted to children in order to oppose the state in a juvenile delinquency proceeding were applied without exception to cases where children oppose their parents' decision to obtain psychiatric help for the children, the result might be to strain, if not irrevocably rupture, the essential emotional relationship between parent and child. *See generally Wolff* v. *McDonnell,* 418 U.S. 539, 563, 567 (1974) ("there would be great unwisdom in encasing the . . . procedures in an inflexible constitu-**

tional straitjacket that would necessarily call for adversary proceedings [that would] very likely raise the level of confrontation"; rules of procedure must be "shaped by the consequences which will follow their adoption"); *Frost* v. *Weinberger,* 515 F.2d 57, 66 (2d Cir. 1975), *cert. denied,* 44 U.S.L.W. 3501 (U.S., Mar. 8, 1976) (extent of procedural safeguards must vary "inversely with the burden and any other adverse consequences of affording it").

Amici must emphasize to the Court that judicial procedures that are commonplace and comfortable for lawyers and judges—presenting testimony in open court, being cross-examined by counsel for an adversary party, etc.—are extremely unpleasant, if not traumatic, for children and parents caught up in what is at best a very difficult emotional process. The most conscientious parents frequently struggle for some time to accept the judgment of a psychiatrist that it is in the best interest of their child to send him or her to a residential institution. "For most parents hospitalization [of their child is] a traumatic experience. . . ." E. HARTMANN, ET AL., ADOLESCENTS IN A MENTAL HOSPITAL 84 (1968).[5] To subject those parents to the additional unpleasant stage of a hearing at which ad-

[5] "For most parents, the placement of a child in a psychiatric treatment facility entails considerable expense and some humiliation." Lessem, *On the Voluntary Admission of Minors,* 8 U. MICH. J. LAW REFORM 189, 203 (1974); *see* Mandelbaum, *Parent-Child Separation: Its Significance to Parents,* in G. WEBER & B. HABERLEIN, RESIDENTIAL TREATMENT OF EMOTIONALLY DISTURBED CHILDREN 68, 74 (1972):

> What are the feelings of parents who face the prospect of residential treatment for their child? . . . [D]uring the admission procedure a universal reaction is that the child's need of residential treatment reveals their inadequacy as parents. They have been found deficient in qualities of goodness.



versary counsel would cross-examine the parents concerning their motivations, good faith, and possibly their own emotional problems,[6] could have significant negative consequences.

First, it might have the effect of deterring some parents from proceeding with needed residential treatment for their children.[7] This is a serious problem because, in spite of the common and frequently justified criti-

[6] *See* Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions,* 62 CAL. L. REV. 840, 889-90 (1974):

> In the hearing, the lawyer will in most cases want to examine the parents as witnesses in order to explore their reasons for seeking the child's commitment, their perceptions of the child's problems, their relationship to the family's problems.

[7] The court below recognized that a parent's decision to institutionalize a child is a difficult one to make and that too many procedural obstacles may deter parents from initiating needed hospitalization (App. 800a):

> A decision to institutionalize a child is often a difficult yet necessary decision for a child's parent to make. It is generally pursued only after all other alternatives have proven futile. The state has an interest in seeing that a procedural system will not deter parents, already faced with this difficult decision, from attempting to institutionalize children who are in need of treatment only mental institutions can provide.

Parents, as a "normal" reaction to their child's emotional illness, look for reasons why they need not or cannot hospitalize their child. *See, e.g.,* Philips, *et al., Intake for Inpatient Care,* in S. SZUREK, I. BERLIN & M. BOATMAN, INPATIENT CARE FOR THE PSYCHOTIC CHILD 66, 68 (1971):

> In our experience . . . many parents of severely disturbed children ask for help in such negative and distorted ways as to half-invite rejection. Requests may be phrased: 'I am calling just to find out how long the waiting list is.'

The additional hurdle of a court hearing, mandated to occur soon after admission, would similarly discourage, or be used as an excuse by, confused, dejected parents who know they ought, yet fear to hospitalize their child.

cisms of our nation's mental health institutions for children,[8] the appropriate form of care and treatment for many [9] retarded or disturbed children still includes residential care for some period.[10] Indeed, studies continue to suggest that one of the fundamental problems

[8] See p. 24 and n. 21, *infra*.

[9] For most disturbed youth, of course, community care is preferable to placement in a large residential institution. *See* JOINT COMM. ON MENTAL HEALTH OF CHILDREN, CRISIS IN CHILD MENTAL HEALTH: CHALLENGE FOR THE 1970's, at 39, 269 (1969):

> Children are best cared for and treated in atmospheres more related to health and normal living than to illness. Every effort should be made to keep the child as closely as possible within his normal setting. This means that we must expand non-hospital treatment arrangements, particularly those that could be operated under the auspices of community-based facilities, such as community mental health centers, educational settings, and social service agencies.
>
> *It is the conviction of this Commission that no child or young person should be placed in a mental hospital without a careful professional diagnosis and without preliminary attempts to help him through other forms of treatment on an out-patient basis in his own home or at least in his home community.* [Emphasis added].

A similar trend is occurring for the mentally retarded. As reported by the President's Committee on Mental Retardation, the total number of residents in public institutions for the mentally retarded decreased more than 10 percent between 1970 and 1975. PRESIDENT'S COMMITTEE ON MENTAL RETARDATION, MENTAL RETARDATION: TRENDS IN STATE SERVICES 29 (1976).

[10] *See, e.g.*, Khan, *"Mama's Boy" Syndrome*, 128 AM. J. PSYCHIATRY 712 (1971). *See generally* Tizard, *et al., Environmental Effects on Language Development: A Study of Young Children in Long-Stay Residential Nurseries*, in S. CHESS & A. THOMAS, ANNUAL PROGRESS IN CHILD PSYCHIATRY AND DEVELOPMENT 705, 728 (1974):

> In conclusion, we would argue that in view of the wide variety of institutional settings, and the evidence from this and earlier studies . . . of their varying effects on development, it is perhaps time to abandon the concept of 'the institution' as a factor in development, and to replace it with a consideration of the effects of different institutional regimens on different aspects of development.

*See also* Rinsley & Inge, *Psychiatric Hospital Treatment of Adolescents*, 25 BULL. OF THE MENNINGER CLINIC 249 (1961); D. HOLMES, THE ADOLESCENT IN PSYCHOTHERAPY 132-41 (1964).



in mental health care today is not "over-institutionalization," but in fact the shortage, due to lack of resources, of high-quality residential institutions. *See* R. GLASSCOTE, M. FISHMAN & M. SONIS, CHILDREN AND MENTAL HEALTH CENTERS, PROGRAMS, PROBLEMS, PROSPECTS 24 (1972) (the number of young people requiring psychiatric treatment is "many times the number who at present are receiving any treatment"); JOINT COMM. ON MENTAL HEALTH OF CHILDREN, CRISIS IN CHILD MENTAL HEALTH, CHALLENGE FOR THE 1970's, at 6 (1969) ("for every child admitted to [a good private residential facility] ten or more are turned away because of lack of space"; "the fact is that only a fraction of our young people get the help they need at the time they need it"). Hospitalization must be considered as only one phase, but sometimes a necessary phase, of the total treatment of the patient. *See, e.g.*, Rabiner & Lurie, *The Case for Psychiatric Hospitalization*, 131 AM. J. PSYCHIATRY 761, 764 (1974). Amici firmly believe that hospitalization is helpful to many patients, both adults and children, and is the treatment of choice for many acute and severe psychiatric conditions.[11] Judicially imposed procedural requirements should not be so onerous that they deter parents from

[11] While reliable empirical data are lacking in this area, "[c]linical impressions do suggest, however, that good residential treatment programs lead to more satisfactory development and functioning in the child than might otherwise have occurred if the child had not been admitted." Lewis & Solnit, *Residential Treatment*, in A. FREEDMAN, ET AL., COMPREHENSIVE TEXTBOOK OF PSYCHIATRY II, at 2249 (1975).

seeking residential psychiatric care for their children in appropriate cases.

Second, hearing procedures can severely strain the relationship between the parent and the child. The aspect of hearings which is most distressing to children relates to the "negative remarks made about them by the parents,"[12] thereby adding to the burden of the family attempting to deal constructively with its problems. In the possibly analogous area of "PINS" cases (dealing with "persons in need of supervision," or minors who traditionally have fallen under the jurisdiction of the juvenile court), studies show that judicial proceedings are "damaging to an already strained family situation":

> Whatever motivates parents to bring their children before the court, the courtroom experience does not generally ameliorate existing animosities, despite the supposedly "protective" nature of the proceeding. To the contrary, able defense attorneys become surrogate parents and necessarily proceed to "destroy" the natural parents verbally on cross-examination before the defendant-child.[13]

Because of these problems, formal adversary proceedings, especially for younger children, may create more family dissension and risk the further breakdown of family structure. *See* Note, *Recognition and Protection of the Family's Interests in Child Abuse Proceedings,* 13 J. FAM. LAW 803, 813 (1974).[14]

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[12] Snyder, *The Impact of the Juvenile Court Hearing on the Child*, 17 CRIME AND DELINQUENCY 180, 189 (1971).

[13] Stiller & Elder, *PINS—A Concept in Need of Supervision,* 12 AM. CRIM. L. REV. 33, 59 (1974).

[14] Indeed, due process hearings, rather than deterring parents from "dumping" their children, in some instances may enhance



Finally, studies have found that in certain instances court hearings create in the child a considerable feeling of uneasiness, if not anger.[15] Based upon clinical experience, Amici have found that younger children, especially, are likely to be intimidated and confused by formal hearing procedures. The course of the child's therapy may be harmed by what the child might perceive as a legal attack during the hearing on the competence and judgment of the child's therapist who is recommending residential treatment.[16]

Not only do hearings create substantial risks of harm in some cases, but their supposed benefits in these situations are often overstated. Unfortunately, the promise of procedural due process as an effective check on

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the likelihood of just such an unwanted and negative outcome. The traditional court sanction directed towards parents who mistreat their children (child abuse, child neglect) is to remove the child from the home. In the situations of concern to the court below ("unneeded" child hospitalization) such a sanction for parental behavior would be meaningless. Confronted by a "victorious" child—one not permitted by a court to be hospitalized—parents may feel they have no other alternative but to turn the care of the child over to the state. Thus, a child who might have been hospitalized, visited by his or her parents, and eventually returned home, instead would be confronted with the complete rupture of the parent-child bond.

[15] Snyder, *The Impact of the Juvenile Court Hearing on the Child*, 17 CRIME AND DELINQUENCY 180, 181 (1971).

[16] *See* Miller, *Children's Rights and the Juvenile Court,* in AMERICAN PSYCHIATRIC ASS'N, SCIENTIFIC PROCEEDINGS IN SUMMARY FORM, 129th ANNUAL MEETING 35, 36 (1976):

> The adversary role of lawyers is antithetical to good child care for a variety of reasons. The disturbed child who goes to court abandons the right to confidentiality and a perceived attack on a therapist may negate the value of therapy. A child may perceive a therapist as being devalued. Repeated legal recheck as to the necessity for treatment can create doubt in the child as to whether the designated helpful person can be trusted.

improper institutionalization frequently proves illusory. Most judicial commitment proceedings are "perfunctory, ritualistic, impersonal, superficial, and presumptive of mental illness." Beran & Dinitz, *An Empirical Study of the Psychiatric Probation-Commitment Procedure,* 43 AM. J. ORTHOPSYCHIATRY 660 (1973). One study of 64 such hearings found that the average hearing lasted only 4.45 minutes, with the court most often accepting uncritically the psychiatric recommendation. *Id.* at 664, 667. Other studies have reached similar conclusions. *See, e.g.,* T. SCHEFF, BEING MENTALLY ILL: A SOCIOLOGICAL THEORY 135 (1971). Thus, simply providing hearing procedures, especially so soon after admission that there is little opportunity for the institutional psychiatrists to present a full report and meaningful evaluation to the tribunal, may not provide the significant protection plaintiffs seek. Nor will it contribute at all to dealing with the larger problem of improving the care and treatment available for mentally ill and retarded children.[17]

Moreover, while advocates of hearing procedures point out that psychiatric commitment in our society unfortunately continues to carry with it an element of

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[17] *See* Tamilia, *Neglect Proceedings and the Conflict Between Law and Social Work,* 9 DUQUESNE L. REV. 579, 589 (1971) ("Equal justice through procedural safeguards that does not require substantive justice for each individual is not enough"); J. POLIER, THE RULE OF LAW AND THE ROLE OF PSYCHIATRY 100 (1968):

> While the progress made in protecting the constitutional rights of the child in the adjudicatory process is to be welcomed, it will in no way compensate for the lack of dispositional remedies. *Gault* may protect some children from unfair hearings and wrongful findings, but it will not provide one dollar's worth of professional mental health services or one hour of care for any troubled child.



stigma, *see* App. 795a,[18] what they overlook is that such stigma is far more likely once a court has heard evidence and made a judicial commitment determination than it would be if a child is admitted voluntarily to a hospital by his or her parents, without court intervention.[19]

It should also be noted that the procedural system mandated by the court below would be extremely time-consuming and expensive. After performing other medical and administrative duties, the average hospital staff psychiatrist is able to devote only 47 percent of his or her time to direct patient care. JOINT INFORMATION SERVICE, ELEVEN INDICES 14 (1971). Any significant increase in the number of hearings required not only would encroach still further into the psychiatrists' limited time for patient care, but also would require the expenditure of substantial amounts of money for legal fees, court personnel, etc.—costs which most likely would be drawn from the already too limited state mental health budgets.[20]

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[18] *See generally* MacMillan, *et al., The Mentally Retarded Label: A Theoretical Analysis and Review of Research,* 79 AM. J. MENTAL DEFICIENCY 241 (1974); Roth, *Some Comments on Labeling,* 3 BULL. AM. ACAD. PSYCHIATRY & LAW 123 (1975).

[19] Indeed, voluntary commitment procedures were designed originally for the very purpose of reducing such stigma.

[20] *See* Friendly, *"Some Kind of Hearing,"* 123 U. PA. L. REV. 1267, 1276 (1975):

> It should be realized that procedural requirements entail the expenditure of limited resources, that at some point the benefit to individuals from an additional safeguard is substantially outweighed by the cost of providing such protection, and that the expense of protecting those likely to be found undeserving will probably come out of the pockets of the deserving.

Amici recognize that abuses do occur under the present system. Unfortunately, all too many of the nation's psychiatric institutions are unaccredited and lack the resources necessary to provide high-quality care and treatment for the many children requiring that assistance.[21] Moreover, there can be no doubt that in some cases unfit parents may seek to abandon their responsibilities by "dumping" their children into an inappropriate residential institution. However, the remedy for these problems must be fashioned carefully by the courts so as not to deter or make unduly difficult the appropriate use of high-quality institutions by the vast majority of conscientious parents who are seeking help for their disturbed or retarded children. In the section that follows Amici will suggest how we believe the Court should balance these factors in order to provide for due process hearing procedures in the situations where they can be most effective, while avoiding the adverse consequences that inevitably would follow from the blunderbuss approach of the lower court.

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[21] *See* JOINT COMM. ON MENTAL HEALTH OF CHILDREN, CRISIS IN CHILD MENTAL HEALTH: CHALLENGE FOR THE 1970's, at 42 (1969) ("most [residential care facilities for mentally ill children] are disgraceful and intolerable"); NATIONAL ASS'N FOR RETARDED CITIZENS, POLICY STATEMENTS ON RESIDENTIAL SERVICES 6 (1968) ("[m]ost residential facilities are still custodial-oriented and lack programs based on individual needs"); *id.* at 6, 9:

> Most residential facilities for the retarded throughout the country are large, overcrowded, and impersonal . . . oftentimes basic health and safety standards are not met . . . many residents . . . are rarely seen by a physician. . . . Abuse, neglect, accidents and questionable deaths are not adequately investigated or reported.



**III. BALANCING THE CHILDREN'S RIGHTS AND THE OTHER CONSIDERATIONS REFERRED TO ABOVE, THIS COURT SHOULD EXCEPT FROM DUE PROCESS HEARING REQUIREMENTS THOSE CASES IN WHICH (1) A PARENT IN AN INTACT FAMILY WISHES TO ADMIT A (2) PRE-ADOLESCENT CHILD TO (3) AN ACCREDITED INSTITUTION (4) FOR A SHORT-TERM PERIOD.**

Amici have demonstrated in Section II above that due process hearing procedures have a very real potential for harm to the interests of both parent and child in certain circumstances. The most serious deficiency of the decision below is that it ignored these potential harms and greatly oversimplified the complex clinical realities in order to fit this case into a traditional, unbending due process mold. The class of plaintiffs before this Court is far from uniform, however, and the procedural requirements best suited to their differing interests must also vary, depending on several key factors totally ignored by the district court.

The interests of the child and the parent, as well as the potential of hearing procedures for either good or harm, will differ radically depending on such factors as (1) the identity of the party seeking the child's psychiatric admission—whether it is a parent, or a state institution such as the welfare department; (2) the age of the child; (3) the quality of the proposed institution; and (4) the duration of the proposed commitment—whether, for example, it is a weekend of "respite care" designed to assist parents of a retarded child, or whether instead it is an indefinite institutionalization of a family's profoundly retarded or disturbed child who may be expected to remain in the institution for many years. Such factors as these were not considered in the district court's undifferentiated ruling requiring the same hearing procedures for all cases. Amici respectfully urge this Court to recognize these very real differences as they relate to the propriety of a traditional due process model, and to bal-

ance these factors so as to except from adversary hearing requirements any instance in which *all* of the following four factors are met: (1) a parent in an intact family wishes to admit a (2) pre-adolescent child to (3) an accredited institution (4) for a short-term period (*e.g.*, less than 45 days). Amici will set out below the considerations that we believe should lead the Court to this resolution.

First, the clearest line that should be drawn is between parent-initiated admissions and those instances in which an institutional guardian, such as a state welfare department, seeks to transfer the child from one institution into another. The dangers of adversary hearing procedures referred to in Section IIB above—such as the risk to the parent-child emotional relationship inherent in such hearings—are not so compelling when it is a state agency, rather than a parent, seeking the admission. Moreover, the interest in parental integrity and the assurance of parental responsibility to minimize risks of abuse are not present in such cases. Accordingly, where a psychiatric admission is sought by a state institution, rather than a parent in an intact family, Amici believe that hearing procedures may be appropriate.

A second factor ignored by the court below is the age of the child. All of the named plaintiffs were fourteen years of age or older at the time of their initial hospitalization. *See* p. 3, *supra*. Nevertheless, the remedy ordered by the district court extends to all children of any age, even those too young to understand or participate meaningfully in the hearing procedures. It is significant to note that the Pennsylvania statute at issue here includes procedures for adolescents sep-



arate from those for pre-adolescents.[22] Amici believe that such an age distinction has a highly significant effect on the impact of hearing procedures on children, and it should be legally recognized. The professional literature establishes that when children reach a *developmental age*[23] of approximately 13 they begin to be significantly more capable of rational and analytical evaluation of their own best interests, as well as articulate expression of their views.[24] Amici believe that Pennsylvania has appropriately determined that adolescent children should be entitled to an opportunity to present their views whenever they disagree with their parents' decision to seek residential care for them. Adolescents will be far less threatened by the hearing

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[22] *See* p. 3, *supra*. Indeed, under the newly enacted state Act, adolescents 14 years of age and older are now treated the same as adults. *See* Section I, *supra*.

[23] The concept of developmental age is quite different from that of chronological age and, in instances where the two differ significantly, developmental age should control. *See generally* T. ACHENBACH, DEVELOPMENTAL PSYCHOPATHOLOGY (1974). For example, severely retarded children by definition will rarely, if ever, have a developmental age placing them in the adolescent range. Mentally ill children, also, will frequently exhibit signs of developmental regression as a symptom of their illness.

[24] The authorities vary somewhat concerning the precise developmental age at which these skills are present. The consensus is that the age range is from 12-14. *See, e.g.*, Schwartz, *Children's Concepts of Research Hospitalization*, 287 NEW ENG. J. MED. 589 (1972); Note, *State Intrusion into Family Affairs: Justifications and Limitations*, 26 STAN. L. REV. 1383, 1395 (1974). *See generally* J. PIAGET, MORAL JUDGMENT OF THE CHILD 17, 40 (1932); A. GESELL, F. ILG, & L. AMES, YOUTH: THE YEARS FROM TEN TO SIXTEEN 175-182 (1956); Neubauer, *Normal Development in Childhood* in B. WOLMAN, MANUAL OF CHILD PSYCHOPATHOLOGY 11 (1972). Amici believe that states should have latitude to select an appropriate age distinction within this general range, as Pennsylvania has done.

procedures and will be much more capable than pre-adolescents of using these procedures effectively.

A third factor which was ignored by the lower court is the quality of the institution being proposed for the child. Amici believe that this factor not only has profound significance from the standpoint of the child and the mental health professional, but also should be relevant to the legal determination of what procedural rules are appropriate in these instances. In balancing the interests of the child in a due process hearing against the other factors referred to in Section II, above, the nature and extent of the possible injury to the child's constitutionally protected interests hardly should be deemed irrelevant. The sad truth is that the quality of mental health institutions today for children throughout the nation varies dramatically. There are many excellent institutions that are fully staffed and possess the resources necessary to provide the child promptly with the treatment best suited to his or her needs. Many other institutions, however, are woefully lacking in trained staff and resources and in some cases may do little more than "warehouse" the children. *See* p. 24 & n. 21, *supra*. The Joint Commission on Accreditation of Hospitals, a recognized professional body which certifies institutions as meeting the minimum standards necessary for appropriate care, has denied accreditation status to numerous institutions throughout the country which are failing to provide adequate mental health care for children and adolescents. Amici believe that the risk of psychological injury to children who are placed in such unaccredited institutions is sufficiently high that it outweighs the possible harm of hearings. Amici recommend that no admission to an unaccredited institution should be



sanctioned by the state absent a due process hearing at which the alternatives to such a placement would be fully evaluated.

Finally, the lower court lumped together in its ruling virtually all admissions, regardless of duration. It required an initial "probable cause" hearing within 72 hours of the child's admission, and it required notice of such hearing to the child and the child's attorney at least 48 hours prior to the hearing. Thus, the appointment of an attorney for the child and the initiation of adversary hearing procedures under the court's order must begin within the first 24 hour Amici believe that in view of the potentially harmful aspects of admission hearings discussed above, a constitutionally imposed procedural rule should not forbid states from taking into account the very significant differences between short-term and long-term institutionalizations. For example, in caring for the retarded it is a generally accepted principle that parents whenever possible should try to keep the child in the home.[25] This can place great strains, both physical and psychological, on the family. Therefore, it is quite common for institutions for the mentally retarded to assist families by making a certain number of beds available for temporary "respite care," helping families to avoid long-term institutionalization of their retarded child by giving them an opportunity for a weekend or short vacation[26] in which they can be relieved of the difficult

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[25] *See generally* W. WOLFENSBERGER, NORMALIZATION: THE PRINCIPLE OF NORMALIZATION IN HUMAN SERVICES (1972).

[26] In Pennsylvania such relief care is available for periods ranging from one day to four weeks. PA. DEPT. OF PUB. WELFARE, OFFICE OF MENTAL RETARDATION, GUIDELINES FOR THE OPERATION OF THE FAMILY RESOURCE SERVICES PROGRAM 9 (1975).

burden of caring for their retarded child 24 hours a day, seven days a week.[27] Under the decision of the court below, any such respite care that lasted more than 72 hours could not be obtained by the parents without incurring the time-consuming, expensive, and emotionally difficult process of a "probable cause" hearing, in which the tribunal presumably would assess whether the parents were being selfish or otherwise acting unreasonably in seeking such assistance. Such a procedure would impose a cruel price on the very people who are trying the hardest to care for their children and to avoid placing that responsibility on the state. To force states to impose such procedures as a constitutional requirement simply makes no sense. Moreover, there are other types of short-term institutional programs (for example, treatment for enuresis, or bed-wetting) which require only a few days' or weeks' residential care and which might properly be treated very differently from cases in which parents are seeking long-term institutionalization for their children.

This Court has already recognized and affirmed the appropriateness of a state's allowing *short-term* psychiatric institutionalization prior to commencement of due process hearing procedures. *Briggs* v. *Arafeh*, 411 U.S. 911 (1973), *aff'g summarily Logan* v. *Arafeh*, 346 F. Supp. 1265 (D. Conn. 1972). In *Arafeh*, this Court affirmed the decision of a three-judge United States District Court rejecting a constitutional challenge to a state statute that authorized involuntary mental hospital commitment of adults who are certified by physi-

[27] The latest data available to Amici indicate that in 1974-75, 525 retarded children in Pennsylvania received such respite care.



cians to be suffering from mental illness and to be dangerous to themselves or others. The statute in question authorized confinement without any prior notice or hearing and provided that if the patient objected to the hospitalization, and the state nevertheless wished to continue the commitment, the patient would receive the right to counsel and an adversary hearing "not more than 45 days" after the initiation of commitment proceedings. *Logan* v. *Arafeh, supra,* 346 F. Supp. at 1267 n. 3. In language that is directly applicable to the instant case, the district court held that the 45-day period before hearing procedures would be required is not only constitutional, but entirely reasonable in light of the expert testimony from professionals in this field (*id.* at 1268-69):

> Testimony received from expert witnesses established that the fifteen day leeway after initial commitment before judicial proceedings must be begun is not simply for the purpose of delay. It has a positive aspect as well. There is a compensating advantage to the committed person because in many cases during this period the medical staff at the hospital can adequately alleviate his mental illness or by use of non-emergency diagnostic procedures determine that he is not a 'danger to himself or others.' In such cases, the stigma of court record is avoided and the length of confinement is shortened. It must be remembered that commitment has not been undertaken for the sake of penal detention. The patient is committed for treatment and care, and some knowledge of his mental condition can be gained by visual observation and diagnostic tests. This takes time. On the other hand, where a full blown court trial must be had pursuant to § 17-178, additional time to undertake more elaborate testing of the patient's mental condition, and a more detailed probe into his relevant his-

tory, by both the hospital authorities and the expert witnesses who will testify in behalf of the patient is needed.

While it is possible that all of this could be concentrated into a shorter period of time, we are satisfied that the time which is allowed by the statute is not so unreasonably long as to amount to a denial of due process. The time provisions set by the legislature are fully supported by the opinions of competent physicians specializing in the treatment and care of persons suffering from mental illness. We hold that there is a rational basis for the time allowed by the statute.

The *Briggs* v. *Arafeh* precedent was followed recently in *Coll* v. *Hyland,* 411 F. Supp. 905, 910 (D.N.J. 1976) (three-judge court) (20-day delay between commitment and hearing constitutional). *See also Saville* v. *Treadway,* 404 F. Supp. 430, 437-38 (M.D. Tenn. 1974) (upholding 45-day "respite care" and six-month "Short-Term Training Admissions" for mentally retarded children, absent hearing procedures); *Fhagen* v. *Miller,* 29 N.Y.2d 348, 278 N.E.2d 615, 328 N.Y.S.2d 393, *cert. denied,* 409 U.S. 845 (1972) (upholding procedure allowing confinement for 15-25 days prior to hearing). The court below in the instant case erred in ignoring that precedent, which is directly applicable here.[28]

The four factors discussed above suggest the type of balancing approach that Amici believe the lower court should have utilized. In cases where the state rather than a parent has initiated the commitment proceeding, there are insufficient countervailing factors to out-

[28] Lower courts are required to give no less precedential weight to this Court's summary affirmances than to its other holdings. *See Hicks* v. *Miranda,* 422 U.S. 332, 344-45 (1975).



weigh the child's right to a due process hearing. Similarly, if the proposed admission is to an unaccredited institution, Amici believe that the risk of harm to the child is high enough to outweigh the potential dangers inherent in hearing procedures—damage to family autonomy, psychological harm of parent-child conflict at hearing, or the possibility that procedures will deter parents from initiating the admission. Also, as discussed above, the age distinction drawn by Pennsylvania in granting to adolescent children the right to be heard in all cases before admission is constitutionally appropriate, in our view, because of the older children's increased ability and interest in expressing their opinions. The final distinction Amici are urging —between short-term and long-term admissions—also flows logically from a consideration of the shifting interests and risks in these cases. A basic premise of admissions for a short period, such as 45 days, is that the parents intend to maintain or strengthen the family unit and will resume care of the child at the end of the 45-day period. Such a period allows for emergency psychiatric intervention, evaluation of the child's psychiatric needs, or short-term intensive treatment. In cases where continued institutionalization appears necessary, the short delay prior to a hearing would assist the mental health professionals in developing the most appropriate information to present to a tribunal concerning the child's condition and their recommended treatment plan. Because the basic premise of a rule allowing short-term institutionalization without prior hearing procedures is that the child will return home shortly, the danger of parental abuse, or "dumping," is lessened significantly. The deprivation to the child in terms of lost liberty is also reduced. Indeed, it is not substantially greater than the loss sustained by a

child hospitalized for a serious but necessary surgical procedure. Given the desirability of minimizing parent-child conflict when it is expected that the child will be returning soon to the family, formal adversary proceedings in these cases should be avoided.

The situation is quite different, of course, when parents seek a long-term institutionalization of their child. Whether such a parental judgment is based on a genuine feeling that it is in the child's best interest, or on a bad faith effort to "dump" the child, it opens the prospect that the parents may terminate the primary intra-family relationship they have had with the child. Even if the parents will be frequent visitors or active participants in the course of institutional treatment, the child's primary frame of developmental reference most likely will shift to some degree from the family to the institution. Thus, the intact family unit is being replaced, through parental choice, by the mental hospital as the primary agent of child rearing during a significant period of child development. Because the parents have chosen to relinquish control of the child to the institution, the possibility of an adversarial conflict between parents and child would not pose as serious a threat to ongoing intra-family relationships in such instances as would be the case when only short-term institutionalization is sought.

Thus, Amici believe that a proper resolution of these factors would require that any due process hearing procedures mandated by the Court should *not* extend to those instances in which *all* of the following four factors are present: (1) a parent in an intact family wishes to admit a (2) pre-adolescent child to (3) an accredited institution (4) for a short-term period (*e.g.*, less than 45 days).



Once it is determined in what instances due process hearings should be required, Amici urge the Court not to limit the states' flexibility in seeking to establish the most appropriate types of forums and procedures to implement that decision. In most instances, the judgment to be made concerning possible institutionalization of a child requires consideration of many factors in addition to the child's mental condition—for example, what is the situation in the home, and how can the most appropriate treatment and counseling for other members of the family be provided? Amici believe that courts may not be the ideal forum for such determinations. Rather, an administrative model for the tribunal that reviews such matters may be the most effective way to include in the decision-making process all of the relevant input, psychiatric as well as legal. *See* Hoffman & Dunn, *Beyond* Rouse *and* Wyatt, *An Administrative-Law Model for Expanding and Implementing the Mental Patient's Right to Treatment,* 61 VA. L. REV. 297 (1975). Such an administrative tribunal might include, for example, a psychiatrist, a lawyer, and another mental health professional.[29] States should be free to experiment with a variety of mechanisms for implementing due process hearing requirements.

Finally, Amici urge this Court, in reviewing the decision below, to insure that whatever rules of procedure are finally mandated will be implemented in a manner

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[29] *See also* Task Force on Mental Health of Children and Youth, *The Rights of a Child To Refuse Treatment,* 1 MANDATE, PENNSYLVANIA'S MENTAL HEALTH NEWSLETTER, Oct. 1973, at 2; Mahan, *et al., A Mechanism for Enforcing the Right to Treatment: The Human Rights Committee,* LAW AND PSYCHOLOGY REV., Spring 1975, at 131, 147-48 (relating to human rights committees).

designed to protect the best interests of each child affected by such rules. The order of the court below requires that all children already admitted to mental hospitals must be "either discharged or released or recommitted according to the procedures required by our opinion and order" within 120 days of the effective date of the order. App. 851a. Amici agree that any new procedural requirements appropriately should be applied retroactively to children already residing in institutions. Indeed, apart from constitutional principles, Amici believe that periodic review of the treatment and condition of mental patients—such as that provided for in Section 108 of the new Act referred to at page 7, above—is desirable from a clinical standpoint. Amici strongly oppose, however, any arbitrary deadline that would require a large number[30] of formal hearing procedures to be initiated at once in order to implement new procedural requirements.[31] Such a deadline would reduce the opportunity of the hearing officials and the mental health professionals to examine each individual case carefully in order to determine the most appropriate future course for each individual patient. Any court order that resulted simply in either *pro forma* hearings or mass de-institutionalization,[32] without regard to the best interests of

[30] The Chief Justice of the Pennsylvania Supreme Court estimates that the decision below would require judicial intervention in 6000-8000 cases within five months. App. 864a.

[31] *See* Reich & Siegel, *Psychiatry Under Siege: The Chronically Mentally Ill Shuffle to Oblivion*, 3 PSYCH. ANNALS 35, 55 (1973) ("[d]ischarges and admissions at the hospitals should be based on individual circumstances rather than follow broad general policy shifts").

[32] *A caution on deinstitutionalization.* The bandwagon for community-based programs is gathering momentum, and it is entirely possible that the precipitous closing of large institutions without sufficient preparation in the community to receive and care for the children released may defeat a fundamentally sensible reform and produce a new crisis in caring. We actually know less about the effects of placing individuals in community settings than we do about the effects of consigning them to large institutions. Thus, progress in a community direction must be accompanied by the development of guidelines that will prevent a movement of children from bad large institutions to bad small ones.
N. HOBBS, THE FUTURES OF CHILDREN, CATEGORIES, LABELS AND THEIR CONSEQUENCES 220 (1975).



the individual patients, would be a cruel deprivation of the rights of the plaintiffs[33] whom the court below and Amici are seeking to protect.

[33] *See* Slovenko & Luby *On the Emancipation of Mental Patients*, 3 J. PSYCHIATRY AND LAW 191, 205-06 (1975):
Mental patients are going from the frying pan into the fire. Under the guise of civil liberties the state mental hospital has been transported to the inner city. It is true that many persons in institutions have been dehumanized through neglect and the failure of society to meet their needs, but turning them back into a so-called community will simply change the geography of neglect, and apparently exacerbate it. In today's world, neglect in the community dwarfs neglect in hospitals. Fundamentally the need that must be faced is the establishment of programs to meet the needs of people whether they are in institutions or in the community.

## CONCLUSION

For the foregoing reasons, Amici respectfully urge this Court to vacate and remand this case in order to allow entry of a new order that will strike an appropriate balance, as outlined in this Brief, between the procedural rights of the plaintiffs and the competing interests that make adversary hearing requirements counter-productive in certain well-defined circumstances.

Respectfully submitted,

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Supreme Court, U. S.
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IN THE

# SUPREME COURT OF THE UNITED STATES

No. 75-1064

JACK B. KREMENS, Individually and as Hospital Director of Haverford State Hospital; FRANK S. BEAL, Individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; WILLIAM B. BEACH, JR., Individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania, -
Appellants,

v.

KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND; Minors, Through Their Next Friend, Individually and on Behalf of All Others Similarly Situated,
Appellees.

Appeal from the Judgment of the United States District Court for the Eastern District of Pennsylvania

## AMICUS CURIAE BRIEF IN SUPPORT OF APPELLEES

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IN THE

# SUPREME COURT OF THE UNITED STATES

No. 75-1064

JACK B. KREMENS, Individually and as Hospital Director of Haverford State Hospital; FRANK S. BEAL, Individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; WILLIAM B. BEACH, JR., Individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,
Appellants,

v.

KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND; Minors, Through Their Next Friend, Individually and on Behalf of All Others Similarly Situated,
Appellees.

Appeal from the Judgment of the United States District Court for the Eastern District of Pennsylvania

## AMICUS CURIAE BRIEF IN SUPPORT OF APPELLEES

## STATEMENT OF INTEREST OF AMICUS CURIAE

The National Juvenile Law Center is a national legal services organization established by the Office of Economic Opportunity (now the Community Services Administration) and funded by a grant to the Saint Louis University School of Law. The function of the National Juvenile Law Center is to work on behalf

of poor persons for reform in the area of juvenile law and the rights of young persons, and to provide assistance to Legal Services Programs, Public Defenders and private attorneys engaged in representing poor persons in juvenile law and related matters. The attorneys employed by the Center also act from time to time as *amicus curiae* in matters of substantial public interest and importance.

Counsel for *amicus* are familiar with the questions involved in this case and believe that it is essential that an additional argument in support of the position of appellees be brought to the attention of this Court.

The National Juvenile Law Center takes an interest in this case because of the importance to the child of the parents' decision to seek his or her commitment to a mental hospital. In addition *amicus* believes that the issues before this Court are substantial and critically affect the public interest and the interest of young persons in general.

## SUMMARY OF THE ARGUMENT

Children possess certain rights which belong to them personally. They possess these rights, however, in the context of the family unit. Parents have rights arising from the parent-child relationship which give them the ability to manage the affairs of the family, including guiding the decisions made by the child. A parents' rights do not, however, give them unfettered control over the child.

When the parent and child find themselves in a situation where their natural alliance is merely an illusion, the parent may no longer be permitted to exercise authority over a decision made by the child concerning any of the child's personal rights. Because of this conflict of interests, the parent cannot act in an unbiased manner, and therefore, may not be permitted to waive a child's rights.



## I. ARGUMENT

**In Transactions Affecting Fundamental Interests of the Child Where the Interests of the Parent and Child Conflict, the Parent May Not Waive Rights Belonging to the Child.**

It has been recognized that children possess certain rights. As this Court has stated: "Constitutional rights do not mature and come into being magically when one attains the state-defined age of majority. Minors as well as adults, are protected by the Constitution and possess constitutional rights." *Planned Parenthood of Central Missouri v. Danforth*, — U.S. —, — S.Ct. —, 44 LW 5197, 5204 (1976). In a line of cases, this Court has extended the protection of certain rights to children in proceedings that could result in confinement in an institution. *See, e.g., Kent v. United States*, 383 U.S. 541 (1966), the right to a hearing on the issue of transfer from the juvenile to the criminal justice system; *In re Gault*, 387 U.S. 1 (1967), the rights to counsel, to present evidence, to cross-examine witnesses, and to notice of the charges; *Breed v. Jones*, 421 U.S. 519 (1975), the right not to be twice put in jeopardy for the same offense. In other situations where the child is found to have a constitutionally cognizable interest, procedural protections have been extended to the child: *Goss v. Lopez*, 419 U.S. 565 (1975), hearing required before a student can be suspended or expelled from school; *Tinker v. Des Moines School District*, 393 U.S. 503 (1967), first amendment freedom of expression applies to children in school.

Children do not possess these rights in a vacuum, but rather exercise these rights in the context of the family unit. Parents may exercise a veto power over a child's decision in certain situations. *Cf. Planned Parenthood Assoc. of Central Mo. v. Danforth, supra.* A parent's right to the companionship and management of his children is one of those liberties, having a basis in

natural law, around which evolved strict constitutional protections. This Court has frequently emphasized the importance of parental rights, deeming it essential, *Meyer v. Nebraska,* 262 U.S. 390, 399 (1923); and recognizing it as one of the "basic liberties", *Skinner v. Oklahoma,* 316 U.S. 535, 541 (1942), and a right "far more precious . . . than property rights," *May v. Anderson,* 345 U.S. 528, 533 (1953). The basic integrity of the family unit is protected not only by the Due Process Clause of the Fourteenth Amendment to the United States Constitution, *Meyer v. Nebraska, supra* at 399, but also by the Equal Protection Clause of the Fourteenth Amendment, *Skinner v. Oklahoma,* supra at 541, and the Ninth Amendment, *Griswold v. Connecticut,* 381 U.S. 479, 496 (1965) for Goldberg, J., concurring.

Despite the highly protected nature of parental rights, the state may intervene in certain circumstances to protect the child from parental behavior. *See, e.g., Prince v. Massachusetts,* 321 U.S. 158 (1944); *In re Trapp,* 528 S.W.2d 489 (Mo. App. 1975); *Hull v. Hull,* 332 S.W.2d 758 (Tex. Civ. App. 1960); *In re Vulon Children,* 288 N.Y.S.2d 203 (Fam. Ct. 1968); *In re Green,* 286 A.2d 681 (Pa. Super. 1971); *In re Neglected Children,* 276 A.2d 14 (Vt. 1971).

In these situations, a conflict exists between the parent and the child. In some circumstances, it may be presumed that a child's parents as his natural guardians are best suited to advocate his interests. However, where the parents' nonfeasance or malfeasance is the subject of the litigation and their fitness as parents is being adjudicated, this presumption can no longer prevail. In *Stapleton v. Dauphin County Child Care Service,* 324 A.2d 562 (Pa. Super. 1974), where parental fitness is in issue, the court found a conflict to exist between a parent or guardian and the child when a resolution of the issue involved a determination of the child's "best interests", and held that the parent cannot waive the child's right to counsel in this situation.



The conflict between parent's right to the care and control of the child and the child's right to self-determination may also be present in delinquency proceedings. For example, this Court has held that there is a right to counsel in a delinquency proceeding in which the juvenile is subjected to the possible loss of liberty by commitment to an institution. *In re Gault, supra.* Where there is a right to counsel, a critical issue is whether that right can be waived, and if so, by whom and under what circumstances. An important problem related to this issue concerns the relationship of the child's parents to this process and their ability to waive counsel for the child. A corollary to this critical question is the capacity of the child to make a knowing and intelligent waiver of the right to counsel (or any right), according to the standards employed to judge an adult waiver. See *Johnson v. Zerbst,* 304 U.S. 458 (1938). Many children lack the degree of sophistication required to assure that the waiver is a knowing and intelligent decision. For this reason, they require the advice and assistance of an adult. However, since the right to counsel is one belonging to the child, the child alone should make the decision. When the parent steps out of the role of advisor, the parent must be barred from interfering in the child's decision.

Even though constitutional rights are of great importance, they may be waived; however, only the person entitled to the right may make an effective waiver. In *K.E.S. v. State,* 216 S.E.2d 670 (Ga. App. 1975), the child's mother had filed complaints with the juvenile court on three occasions stating that her daughter was unruly. At a probation revocation hearing where the child was entitled to be represented by counsel, the court found that the mother's waiver of her daughter's right was ineffective. Under the circumstances of this case, the court stated that the mother and daughter clearly had conflicting interests, and further stated that "the mother who waives the child's right must be an unbiased mother, free of interests conflicting with the needs of her daughter . . . The mother's waiver of

counsel, here, therefore, is not binding upon the child." 216 S.E.2d at 673.

Other courts have reached similar conclusions. In *Commonwealth v. Starkes*, 335 A.2d 698 (Pa. 1975), a minor's confession was suppressed after the court found that the confession was obtained due to the influence exerted by the child's parent who had not been informed of the consequences of making such a statement. *See also: Bridges v. State*, 299 N.E.2d 616 (Ind. 1973); *McBride v. Jacobs*, 247 F.2d 595 (D.C. Cir. 1957); *Shioutakon v. Dist. of Columbia*, 236 F.2d 666 (D.C. Cir. 1956).

Legislatures of various states have recognized that this conflict of interest exists and have responded by enacting provisions in the state's juvenile code to remedy this problem. A number of statutes deal indirectly with the waiver of rights issue by requiring separate counsel for the parent and child where a conflict is found to exist. *See, e.g.*, Ariz. Stat. § 8-225 (1974); Minn. Rules of Juv. Ct. Rule 2-1(4); N.D. Cent. Code § 27-20-26 (1960); Ohio Rev. Code § 21.51.352 (1971); Vt. Stat. Ann. tit. 33 § 653 (1959); Tenn. Code Ann. § 37-226 (1974); Cal. Welf. & Inst'ns. Code § 634 (1972); Mo. Rules of Juv. Ct. Rule 116(g); Pa. Stat. Ann. tit. 11 § 50-317 (1965). Separate counsel is employed in this situation in order to independently evaluate and advocate the interests of the parties and to objectively offer advice. A parent, although presumably the protector and ally of the child, cannot serve in that capacity since the tensions produced by the conflict bias his ability to act as an advisor. *See, K.E.S. v. State, supra.* One state has not only recognized that the conflict exists, but has legislated that the parent may not waive any right belonging to the child. Ky. Rev. Stat. § 208.060(3)(e) (1974). Legislative activity in the form of bills pending before state houses, lends additional recognition to the existence of the parent-child conflict by explicitly providing that the parent may not waive a child's right. *See, e.g.,*



Wash. S.B. 2232 (1975); Wash. H.B. 496 (1975). *See also, Piersma*, Ganousis and Kramer, *The Juvenile Court: Current Problems, Legislative Proposals, and a Model Act*, 20 St. L. U. L. J. 1, 30, 92 (1975).

Thus, the role parents play at proceedings in which their children are involved is that of an advisor. In this capacity, the parent's duty is to assess the situation, serve as a buffer against the coercive nature of the surroundings, and offer advice and assistance to the child, so that the child can decide whether to waive his rights. The parent is not present to make decisions for the child nor to waive any right belonging to the child. Often the child is before the court due to parental initiation of the proceedings, *e.g.*, filing of a petition alleging that the child is beyond control, or that the child requires care because of a mental or emotional disorder. It has been shown that in such a situation the parent and the child are adversaries, not allies. *K.E.S. v. State, supra.* To permit the parent to file charges and then to waive the child's right at any subsequent stage of a proceeding arising from the charge is grossly unfair.

Permitting separate counsel for the child and prohibiting parental waiver in these circumstances will neither disrupt the family unit nor diminish parental authority. Certain rights have been guaranteed to the minor by federal and state law. The government may not abridge the exercise of these rights nor coerce any person into waiving the protection the rights guarantee. To allow a parent to waive the right for the child is tantamount to delegating authority over another person's rights to the parent. Such authority is beyond the normal scope of parental decision-making. See, *e.g.*, *Wisconsin v. Yoder*, 406 U.S. 205 (1972). In a similar case, this Court refused to permit a parent to exercise a veto over a minor's decision to have an abortion, recognizing that the "minor and the nonconsentive parent are so fundamentally in conflict . . ." *Planned Parenthood of Missouri v. Danforth, supra*, at 5204.

## II. CONCLUSION

It is, therefore, submitted that despite a parent's legitimate interest in the preservation of the family unit through the exercise of authority over a child's decision, a parent may not be permitted to waive the child's rights at any stage of a proceeding in which they are involved. The child personally possesses constitutional rights and has the ultimate right to exercise or to waive them. The parent, as the child's ally, should serve as an advisor and assist the child in reaching an informed decision. Whenever the parent becomes the child's adversary, in those situations where a conflict of interests exists, the parent may not be permitted to interfere with the exercise of a child's constitutionally protected rights.

Respectfully submitted

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**Certificate of Service**

I, Michael A. Wolff, Counsel for Amicus Curiae, do hereby certify that I have served by United States Mail, postage prepaid, first class, on this date, August 2, 1976, three copies of Appellees' Brief for Amicus Curiae to Norman J. Watkins, Deputy Attorney General, Counsel for Appellants, at Department of Justice, Capitol Annex, Harrisburg, Pennsylvania, 17120. I further certify that all parties required to be served in this appeal have been served.

MICHAEL A. WOLFF
Counsel for Amicus Curiae

Supreme Court, U. S.
FILED
AUG 4 1976
MICHAEL RODAK, JR., CLERK

IN THE

# Supreme Court of the United States

OCTOBER TERM, 1975

**No. 75-1064**

JACK B. KREMENS, Individually and as Hospital Director of Haverford State Hospital; FRANK S. BEAL, Individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; WILLIAM B. BEACH, JR., Individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania, *Appellants*

v.

KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND, Minors, Through Their Next Friend, Individually and on Behalf of All Others Similarly Situated, *Appellees*

**On Appeal from the Judgment of the United States District Court for the Eastern District of Pennsylvania**

## BRIEF OF THE AMERICAN BAR ASSOCIATION AMICUS CURIAE

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IN THE

# Supreme Court of the United States

OCTOBER TERM, 1975

No. 75-1064

JACK B. KREMENS, Individually and as Hospital Director of Haverford State Hospital; FRANK S. BEAL, Individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; WILLIAM B. BEACH, JR., Individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania, *Appellants*

v.

KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND, Minors, Through Their Next Friend, Individually and on Behalf of All Others Similarly Situated, *Appellees*

**On Appeal from the Judgment of the United States District Court for the Eastern District of Pennsylvania**

## BRIEF OF THE AMERICAN BAR ASSOCIATION AMICUS CURIAE

### INTEREST OF AMICUS CURIAE

The American Bar Association is a national membership organization of the legal profession. It counts as members more than 208,000 lawyers from all states

and has since 1944 maintained an active interest in the field of mental disability law.[1] This interest was intensified in 1973 when the Board of Governors of the American Bar Association established a Commission on the Mentally Disabled, a 17-member interdisciplinary body charged with promoting effective legal assistance to the mentally disabled and with recommending and implementing programs designed to correct systemic deficiencies in the nation's mental disability system. Since its inception, the Commission on the Mentally Disabled has focused its efforts toward, *inter alia,* mobilizing and activating local and state bar associations with regard to legal representation of the mentally disabled (including appropriate backup and support) and has instituted a model monitoring and advocacy project at a state hospital in Pennsylvania.

The Association has also taken the lead in establishing standards for the administration of justice, such as its Standards for the Administration of Criminal Justice and its Standards Relating to Trial Courts (see *infra*). Thus the Association is uniquely experienced and interested in the question now before this Court.

With due consideration of the extended factual legal analysis offered in the briefs of the parties and other *amici,* the Association, with the written consent of the

[1] The Association established a Special Committee on the Rights of the Mentally Ill 32 years ago; this committee's recommendations led ultimately to the publication of a number of path-breaking studies by the American Bar Foundation, created by the Association in 1952. See Lindman & McIntyre, *The Mentally Disabled and the Law* (1961); Rock, Jacobson, & Janopaul, *Hospitalization and Discharge of the Mentally Ill* (1968); Matthews, *Mental Disability and the Criminal Law* (1970); Brakel & Rock, *The Mentally Disabled and the Law* (rev. ed. 1971).



parties,[2] sets forth its views herein on the important question of whether, and to what extent, the Constitution requires procedural safeguards for minors facing civil commitment on the basis of alleged mental disability.

## QUESTION PRESENTED BY AMICUS

Whether the due process clause of the Fourteenth Amendment applies to involuntary civil commitment of children on the basis of alleged mental disability, and if so, whether due process requires substantially the same procedural protections for such children as it does for adults.

## STATEMENT OF THE CASE

On November 16, 1972, plaintiffs, patients in Pennsylvania's Haverford State Hospital, filed this class action pursuant to 28 U.S.C. §§ 1331 and 1343(3) and 42 U.S.C. § 1983 in the United States District Court for the Eastern District of Pennsylvania. A three-judge court was sought and convened pursuant to 28 U.S.C. §§ 2281, 2284. The action was brought against the Director of Haverford State Hospital and officials of the Pennsylvania Department of Public Welfare, on behalf of all mentally ill and mentally retarded children (18 years of age or younger) indefinitely admitted or committed to mental institutions under Section 402 and 403 of the Pennsylvania Mental Health and Mental Retardation Act of 1966, 50 P.S. §§ 4402, 4403.

The minor plaintiffs alleged that the Pennsylvania statutory procedure constituted a denial of due process

[2] Copies of letters indicating the parties' consent have been filed with the Clerk of the Court.

and equal protection of the law under the Fourteenth Amendment to the Constitution of the United States. The statutes in question provide that persons 18 years of age or younger may be institutionalized upon the application of a parent, guardian, or person *in loco parentis*; such institutionalization is considered a "voluntary" admission or commitment.[3] The admission/commitment procedure under challenge provides no opportunity for a hearing or assistance of counsel and merely requires a finding by the director of the facility upon admission that the child "is in need of care or observation."

On July 24, 1975, the District Court ruled on due process grounds, one judge dissenting, that the voluntary admission and commitment procedures of 50 P.S. §§ 4402 and 4403 were unconstitutional as applied to children 18 years of age or younger. 402 F.Supp. 1039. Central to the court's holding was its determination that "a child's interest in not being institutionalized . . . is safeguarded by the Fourteenth Amendment." 402 F. Supp. at 1046-1047.

The District Court specifically rejected defendants' argument that due process protections should not apply because the state is acting as *parens patriae* and not as an adversary in the admission/commitment of children, and because the admission/commitment proceedings are civil, not criminal, in nature. The court held that such reasoning ignores the fact that the child in question is involuntarily removed from his home and community; the stigma associated with civil commitment;

[3] The record in this case indicates that "voluntary" admissions or commitments are often against the expressed wishes of members of the plaintiff class, and are frequently based upon reasons unrelated to the mental condition of the child involved. 402 F.Supp. at 1044; A. 210-221.



and the possibility of erroneously and wrongfully depriving children of their liberty by committing them to mental institutions without proper fact-finding procedures. 402 F.Supp. at 1045-1047. The court also found, on the basis of facts in the record, that "[i]n deciding to institutionalize their children, parents, as well as guardians ad litem or persons standing in loco parentis, may at times be acting against the interest of their children," and thus should not be authorized to waive personal constitutional rights of their children. 402 F.Supp. at 1047-1048.

The District Court then enumerated a range of procedural guarantees which it said must be afforded prior to institutionalization of members of the plaintiff class on the basis of alleged mental disability:

> (1) a probable cause hearing within seventy-two (72) hours from the date of their initial detention; (2) a post-commitment hearing within two (2) weeks from the date of their initial detention; (3) written notice, including the date, time, and place of the hearing, and a statement of the grounds for the proposed commitment; (4) counsel at all significant stages of the commitment process and if indigent the right to appointment of free counsel; (5) [presence] at all hearings concerning their proposed commitment; (6) a finding by clear and convincing proof that they are in need of institutionalization; (7) the rights to confront and to cross-examine witnesses against them, to offer evidence in their own behalf, and to offer testimony of witnesses. 402 F.Supp. at 1053.

In its opinion, 402 F.Supp. at 1053 n.26, and its implementing order of November 17, 1975 (A. 831), the court specified that with the exception of notice and counsel, all of the above listed protections could be

waived in appropriate cases by a child or, in some instances, by counsel, subject to approval by the "unbiased tribunal" which was to be the forum for the hearings on commitment.[4]

The defendants appealed the judgment of the District Court to this Court pursuant to 28 U.S.C. § 1253, and made application for a stay pending appeal. A stay was denied by the trial court but subsequently granted by this Court on December 15, 1975. Probable jurisdiction was noted by this Court on March 22, 1976.

## SUMMARY OF ARGUMENT

Civil commitment of an individual on grounds of alleged mental illness or retardation is a constitutionally significant deprivation of personal liberty which carries with it serious adverse consequences and disabilities. Such deprivations and disabilities may not constitutionally be imposed without due process of law (in the form of adequate procedural safeguards), where the commitment of the individual is involuntary, in fact or in law. Fact finding procedures are particularly important where, as here, the risk of error is substantial, and where, as here, identification of less restrictive appropriate alternatives may obviate the need for commitment to a mental institution.

The asserted interest of the state in providing treatment to mentally disabled juveniles and in preserving the family unit does not justify a substantially different or less stringent application of the due process

[4] This tribunal was not necessarily required to be a court, 402 F. Supp. at 1049 n.18, and indeed the state was left free to develop alternative procedural safeguards which would be as effective as those specified by the court. 402 F.Supp. at 1048 n.16.



clause with respect to mental disability commitments of children. While parents, of course, can and should be involved in any decision to institutionalize a child, it cannot be assumed in every case that the parent is acting in the best interest of the child. Thus the final commitment decision should be made, pursuant to appropriate procedures, by an objective and unbiased tribunal.

## ARGUMENT

### 1. Placement in a Mental Institution Is a Constitutionally Significant Deprivation of Liberty and Carries With It Other Serious and Important Adverse Consequences.

*Loss of liberty.* Commitment to a mental institution necessarily entails a "massive curtailment of liberty," *Humphrey* v. *Cady,* 405 U.S. 504, 509 (1972), and inevitably affects "fundamental rights." *Baxstrom* v. *Herold,* 383 U.S. 107, 113 (1966). Perhaps the most basic aspect of constitutional liberty is the right to be free from unwarranted physical confinement. *Arnett* v. *Kennedy,* 416 U.S. 134, 157 (1974). Avoiding extreme restrictions on personal liberty such as those imposed by involuntary civil commitment has been held by this Court to be an interest of "transcending value." *In re Winship,* 397 U.S. 358, 364 (1970).

Although there may be differences between the involuntary commitment of an adult, where the state may assume a more active role, and the commitment of a minor, in which the parents are more directly involved, the results in terms of physical and emotional deprivations are, if different in kind, at least equal in impact and severity.[5] Adults and children alike are deprived of their basic right to personal liberty; all are removed from their homes, communities, and normal daily activities, and subjected to the custody and control of persons (usually agents of the state) not of their own choosing.

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[5] Parental or familial involvement is not uncommon in the civil commitment of adults. See *O'Connor* v. *Donaldson,* 422 U.S. 563, 565 (1975), where the petitioner was committed at the instance of his parents and spent 15 years in the Florida State Hospital for the mentally ill.



A commitment of a minor to an institution may be a traumatizing disruption of his life which cannot fail to have far-reaching consequences. A committed child is separated from a known environment of family, friends, and school and plunged into a frightening, unfamiliar world. See *In re Gault,* 387 U.S. 1, 27 (1967). As one lower court has put it, perhaps a bit sentimentally but nonetheless accurately, in a case similar to the one at bar:

> Like *O'Connor* v. *Donaldson,* 422 U.S. 563, 95 S.Ct. 2486, 45 L.Ed.2d 396, (1975), and the question therein posed and answered, this case raises the most important question of every child's constitutional right to liberty, not only the liberty that includes freedom from bodily restraint, but also the liberty that includes the freedom of an ordinary, every-day child in the United States of America —the freedom to live with mothers, fathers, brothers and sisters in whatever the family abode may be; the freedom to be loved and to be spanked; the freedom to go in and out the door, to run and play, to laugh and cry, to fight and fuss, to stand up and fall down, to play childish games; the freedom to go to school and to frolic with school mates; the freedom to go to Sunday school and church; the freedom to watch and listen or not to watch and listen to television; the freedom to buy candy at the corner store; the freedom to be a normal child in a normal household cared for by normal parents. *J.L.* v. *Parham,* 412 F.Supp. 112, 136 (M.D.Ga. 1976). (Footnote and citation omitted.)

Testimony at the trial in this case established the destructive consequences of removing a child from familiar surroundings and the difficulty of subsequent reintegration into his once familiar world (A. 620-621). The feeling of abandonment occasioned by institution-

alization is especially intense for younger children who are adversely affected by such feelings sooner than older children. Goldstein, Solnit & Freud, *Beyond the Best Interest of the Child,* 40-49 (1973). Institutionalization may also retard the normal intellectual and emotional development of a child.[6] Thus there is no reason to assume that the institutionalization decision, and the fact of institutionalization, are of any less consequence for minors than for adults (A. 575). If anything, the opposite appears to be the case.

*Involuntary treatment.* In addition to the deprivation of liberty inherent in an indefinite commitment, such commitment carries with it the risk of physically intrusive treatment which, especially if unwarranted, may violate the committed individual's right to bodily integrity. See *Schmerber* v. *California,* 384 U.S. 757, 772 (1966); *Rochin* v. *California,* 342 U.S. 165 (1952). Such treatment modalities may include forced administration of psychotropic medication, see *Winters* v. *Miller,* 446 F.2d 65 (2nd Cir. 1971), *cert. den.* 404 U.S. 985 (1971); aversive conditioning, see *Knecht* v. *Gillman,* 488 F.2d 1136 (8th Cir. 1973) and *Mackey* v. *Procunier,* 477 F.2d 877 (9th Cir. 1973); convulsive therapy, see *Wyatt* v. *Hardin,* No. 3195-N (M.D. Ala., February 28, 1975, June 26, 1975, and July 1, 1975); and even psychosurgery, see *Kaimowitz* v. *Michigan*

[6] Glenn, "The Least Restrictive Alternative in Residential Care and the Principle of Normalization," in *The Mentally Retarded Citizen and the Law,* at 499-501 (1976); Hobbs (ed.), *Issues in the Classification of Children,* at 135, 142-43 (1975); Joint Commission on the Mental Health of Children, *Crisis in Child Mental Health: Challenge for the 1970's,* at 321-324, 330-331 (1970); Provence & Lipton, *Infants in Institutions,* at 19 (1962).



*Department of Mental Health,* No. 73-19434-AW (Cir. Ct. Wayne County, Mich., July 10, 1973).[7]

Of course, not every institutionalized minor will be subjected to hazardous or intrusive procedures, but the fact is that institutionalization, to some degree, confers upon the state (or perhaps, upon a private facility through the authority of the state) the power to impose treatment upon an institutionalized individual—treatment which by its very nature may involve "impermissible tinkering with mental processes," *Mackey* v. *Procunier, supra,* 477 F.2d at 877, or a violation of the right to privacy. See *Roe* v. *Wade,* 410 U.S. 113 (1973); *Griswold* v. *Connecticut,* 381 U.S. 479 (1965). Obviously, no one, especially a child, should be exposed to the risk of such treatment without prior determination that it is warranted and appropriate.

*Stigmatization.* As courts have noted,[8] institutionalization on mental disability grounds almost inevitably stigmatizes the individual involved in a way that adversely affects him the rest of his life. Such stigmatization may result in or be accompanied by the scorn or obloquy of one's peers, loss of employment possibilities and education benefits, and other civil disabilities that flow from institutionalization (A. 569, 574-575, 621-622, 634, 657).[9] In these circumstances, see *Paul* v.

[7] See generally Friedman, "Legal Regulation of Applied Behavior Analysis in Mental Institutions and Prisons," 17 Ariz. L. Rev. 39 (1975).

[8] *E.g., Lessard* v. *Schmidt,* 349 F.Supp. 1078, 1088-90 (E.D. Wis., 1972), *vacated on procedural grounds* 414 U.S. 473 (1974), *on remand* 379 F.Supp. 1376 (E.D. Wis. 1974), *vacated on procedural grounds* 421 U.S. 957 (1975), *on remand* No. 71-C-7602 (E.D. Wis., May 28, 1976).

[9] *Cf.* Comment, "Developments in the Law—Civil Commitment of the Mentally Ill," 87 Harv. L. Rev. 1190, 1198-1201 (1974).

*Davis,* —— U.S. ——, 96 S.Ct. 1155, 1163-1165 (1976), an individual's interest in his good reputation is a liberty (or property) interest entitled to constitutional protection. *Board of Regents* v. *Roth,* 408 U.S. 564, 573 (1972); *Wisconsin* v. *Constantineau,* 400 U.S. 433 (1971).

*Possibility of inhumane or inadequate treatment.* It is unfortunate but true that many of our nation's public mental institutions do not provide minimally adequate habilitative or rehabilitative programming, but in fact may subject their patients or residents to inhumane and unsafe living conditions, destructive psychological pressures, and even physical abuse by other patients or residents or by staff members, all in violation of constitutional guarantees. As in *In re Gault, supra,* 387 U.S. at 15-21, this Court should take note of this possibility, which has been well documented by lower Federal courts,[10] in determining the procedural protections which should attend the commitment of anyone, especially a child, to a mental institution.

[10] *E.g., O'Connor* v. *Donaldson, supra; Wheeler* v. *Glass,* 473 F.2d 983 (7th Cir. 1973); *Davis* v. *Watkins,* 384 F.Supp. 1196 (N.D. Ohio 1974); *Welsch* v. *Likins,* 373 F.Supp. 487 (D. Minn. 1974), *enforced* No. 4-72-Civ. 451 (D. Minn., October 1, 1974); *New York State Association for Retarded Children and Parisi* v. *Rockefeller,* 357 F.Supp. 752 (E.D.N.Y. 1973), *modified* No. 72-C-356/357 (E.D.N.Y., May 23, 1973), *order on consent sub nom. New York State Association for Retarded Children and Parisi* v. *Carey,* No. 72-C-356/357 (E.D.N.Y., April 30, 1975), *approved* 393 F.Supp. 715 (E.D.N.Y. 1975); *Horacek* v. *Exon,* 354 F.Supp. 71 (D. Neb. 1973), *order on consent* No. 72-L-299 (D. Neb., October 31, 1975); *Wyatt* v *Stickney,* 325 F.Supp. 781 (M.D. Ala. 1971), 334 F.Supp. 1341 (M.D. Ala 1971), 344 F.Supp 373 and 387 (M.D. Ala. 1972), *aff'd sub nom. Wyatt* v *Aderholt,* 503 F.2d 1305 (5th Cir. 1974). *Cf.* Gruenberg, "The Social Breakdown Syndrome—Some Origins," 123 Am. J. Psychiatry 12 (1967); Barton, *Institutional Neurosis* (2d ed. 1966); Goffman, *Asylums* (1961).



This Court's decision will have nationwide effect,[11] and in those jurisdictions where the above described conditions exist, the consequences of erroneous institutionalization decisions are especially grave.

As with all the other types of deprivations and adverse consequences mentioned above, no reason appears why such infringements of constitutionally protected rights are of any less consequence in the case of children than they are in the case of adults (A. 575).

**2. Confinement in a Mental Institution Cannot Be Constitutionally Imposed by the State or Under the Authority of State Law Without Adequate Procedural Safeguards.**

This Court has consistently recognized that prior to a deprivation of a constitutionally protected interest, the due process clause demands that procedures be established to determine the necessity and legal justification for the proposed deprivation. This Court has adopted a flexible approach by tailoring the procedural requirements according to the weight of the competing individual and governmental or societal interests at stake. See, *e.g., Wolff* v. *McDonnell,* 418 U.S. 539 (1974); *Morrissey* v. *Brewer,* 408 U.S. 471, 481-90 (1972); *Bell* v. *Burson,* 402 U.S. 535, 539-42 (1971); *Boddie* v. *Connecticut,* 401 U.S. 371 (1971); *Goldberg* v. *Kelly,* 397 U.S. 254, 263-71 (1970); *Cafeteria Workers Union* v. *McElroy,* 367 U.S. 886, 895 (1961).

While this Court has not ruled directly on the procedural requirements for civil mental disability commitments, it has mandated strict procedural safeguards

[11] As late as 1974, 39 out of the 50 states permitted "voluntary" institutionalization of children by their parents or guardians. Ellis, "Volunteering Children: Parental Commitment of Minors to Mental Institutions," 62 Calif. L. Rev. 840 n.1 (1974).

in the analogous areas of quasi-criminal commitments, *Specht* v. *Patterson,* 386 U.S. 605 (1967), and institutionalization of juvenile delinquents, *e.g., In re Winship, supra; In re Gault, supra.* Indeed, the Chief Justice noted in his concurring opinion in *O'Connor* v. *Donaldson, supra,* 422 U.S. at 580, that

> [t]here can be no doubt that involuntary commitment to a mental institution, like involuntary confinement of an individual for any reason, is a deprivation of liberty which the State cannot accomplish without due process of law .... Commitment must be justified on the basis of legitimate state interest, and the reason for committing a particular individual must be established in an appropriate proceeding. (Citations omitted.)

Numerous lower Federal courts, relying in part on the above cited cases, have struck down civil commitment statutes found to be deficient in procedural safeguards. *Stamus* v. *Leonhardt,* No. 73-126-2 (S.D. Iowa, May 20, 1976); *Suzuki* v. *Quisenberry,* 411 F.Supp. 1113 (D. Hawaii 1976); *Doremus* v. *Farrell,* 407 F.Supp. 509 (D. Neb. 1975); *Kendall* v. *True,* 391 F.Supp. 413 (W.D. Ky. 1975); *Lynch* v *Baxley,* 386 F.Supp. 378 (M.D. Ala. 1974); *Bell* v. *Wayne County,* 384 F. Supp. 1085 (E.D. Mich. 1974); *Lessard* v. *Schmidt, supra; Dixon* v. *Attorney General of the Commonwealth of Pennsylvania,* 325 F.Supp. 966 (M.D. Pa. 1971). *Cf. State ex rel. Hawks* v. *Lazaro,* 202 S.E. 2d 109 (W. Va. 1974); *Denton* v. *Commonwealth,* 383 S.W. 2d 681 (Ky. 1964).

Indeed, many courts other than the District Court in the instant case have similarly held due process requirements applicable specifically to mental disability commitments of children. *J.L.* v. *Parham, supra; Saville* v. *Treadway,* 404 F.Supp. 430 (M.D. Tenn. 1974); *Kidd* v. *Schmidt,* 399 F.Supp. 301 (E.D. Wis. 1975). *Cf. Pima County Public Fiduciary* v. *Superior Court,* 546 P.2d 354 (Ariz. Ct. App. 1976).



**A. The District Court's Emphasis on the Right to Adequate Notice and to Counsel Was Appropriate in Light of Applicable Precedent and the Factual Record.**

The lower court cases have concluded, in particular, that the requirements of due process include the right to meaningful notice given sufficiently in advance of any proceedings so as to apprise the individual of the grounds for the proposed commitment along with the procedural and substantive rights afforded him. *Suzuki* v. *Quisenberry, supra,* 411 F.Supp. at 1127; *Doremus* v. *Farrell, supra,* 407 F.Supp. at 515; *Lynch* v. *Baxley, supra,* 386 F.Supp. at 388; *Bell* v. *Wayne County, supra,* 384 F.Supp. at 1092; *Lessard* v. *Schmidt, supra,* 349 F.Supp. at 1092. In addition, the lower court opinions have uniformly held that an individual faced with the prospect of involuntary commitment for an indefinite period is entitled to the effective assistance of counsel, including the appointment of counsel if the individual cannot afford retained counsel, and that counsel must be made available far enough in advance of any hearing to provide adequate opportunity for preparation. *Suzuki* v. *Quisenberry, supra,* 411 F.Supp. at 1129; *Doremus* v. *Farrell, supra,* 407 F.Supp. at 516; *Lynch* v. *Baxley, supra,* 386 F.Supp. at 389; *Bell* v. *Wayne County,* 384 F.Supp. at 1093-94; *Lessard* v. *Schmidt,* 349 F.Supp. at 1097-98. *Cf. Heryford* v. *Parker,* 396 F.2d 393, 396 (10th Cir. 1968).

In the instant case, the court mandated that notice and the appointment of counsel be nonwaivable, al-

though other procedural requirements may be waived if an unbiased tribunal finds that such a waiver is in the best interest of the child. 402 F.Supp. at 1053 n.26; Order of November 17, 1975 (A. 831). This approach takes into account the unique aspects of a juvenile mental disability commitment, where the child may in certain situations be more subject to implicit or explicit coercion and less likely to appreciate or comprehend the nature of the proceedings,[12] and in other cases may, after consultation with counsel, be in a position to dispense with other formal procedures. Thus the court below merely adopted a logical method both to prevent abusive practices in securing waivers and to eliminate time-consuming and unnecessary challenges to a child's commitment.

Supplementing the legal authority for the appointment of counsel was testimony by psychiatric experts at the trial who agreed that counsel played an important therapeutic role in the proceedings for all involved. The testimony indicated that the advocate for the child is the only individual who can be perceived by the child as representing his interests in the commitment proceedings. Despite assurances to the contrary from parents or the psychiatrists, the child is likely to perceive their role as adversarial. Appointment of counsel for the child thus decreases the chance that the child will feel "railroaded" and makes him more amenable to treatment if commitment is ordered (A. 542-544).

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[12] See A. 590, 630-631.



**B. The Right to Counsel, in Particular, Has Been Emphasized by the American Bar Association as a Matter of Sound Judicial Administration.**

Appointment of counsel along the lines of the lower court's order has been incorporated into the Standards Relating to Trial Courts drafted by the American Bar Association Commission on Standards of Judicial Administration and adopted by the Association's House of Delegates at its mid-year meeting in February, 1976. Section 2.72 of the trial court standards, which sets forth the procedural requirements for civil commitment proceedings, specifically provides that persons subject to such proceedings are entitled to the assistance of counsel as provided in Section 2.20. That section, in addition to permitting a litigant to employ counsel in any judicial proceeding, requires that counsel be appointed for persons unable to afford their own counsel when they are "subject to a civil proceeding in which the result may be detention for a period longer than 72 hours."

In its commentary with regard to this standard, the Commission on Standards of Judicial Administration noted:

> In addition to representation in criminal cases, counsel should be appointed to represent any person who is the subject of a civil proceeding in which the result may be his physical commitment or detention for any period beyond brief emergency detention. Such proceedings include commitment of the mentally ill, mentally deficient, narcotics addicts, alcoholics, "defective delinquents," "sexual psychopaths," and similarly defined persons. The distinction between these procedures and criminal prosecution is often more theoretical than real, for the state plays an ad-

> versary role, as in criminal cases, and the consequence of adjudication may be long confinement—sometimes for an indefinite period—in an institution where the conditions of custody to a greater or lesser degree resemble a prison. A like necessity for counsel exists in deportation and contempt proceedings. Where the individual involved is mentally disturbed or deficient, or lacks facility in speaking English, the need for counsel is all the more urgent because the person cannot speak effectively for himself.

Clearly, the commitment of a minor falls within the type of situation contemplated by Standard 2.20.

As noted *supra,* the court below enumerated other procedural rights for children facing commitment, all of which find support in some or all of the above cited precedents.[13] *Amicus* would point out also that Section 2.72 of the above described trial court standards and the order entered by the court below are strikingly similar, in that both contemplate a preliminary and final hearing, the right to notice, counsel, and personal presence at such hearings, along with the rights of confrontation and cross-examination and of presenting evidence on one's own behalf. (The complete text of Section 2.72 and accompanying Commentary is attached as the appendix to this brief.)

**C. The District Court Was Correct in Finding That the Pennsylvania Scheme for Admission or Commitment of Children Does Not Satisfy the Requirements Enumerated Above.**

A plain reading of the Pennsylvania statutes here in question, 50 P.S. §§ 4402 and 4403, demonstrates that

[13] The utility of particular procedural safeguards may vary to some extent depending on the age and maturity of the child involved.



they afford children subject to institutionalization none of the procedural protections mandated by the above cited constitutional decisions or endorsed by the American Bar Association.[14] The fact that the statutes provide for screening of the children at the receiving facility does not cure this total lack of due process safeguards. As another District Court noted in a decision striking down a similar juvenile commitment scheme in Georgia:

> The court is impressed by the conscientious, dedicated state employed psychiatrists who, with the

[14] After filing of this lawsuit, the Pennsylvania Department of Public Welfare promulgated regulations affording minors 13 years of age or older the opportunity to object to their institutionalization. 402 F.Supp. at 1042 n.5. As plaintiffs contended, 402 F.Supp. at 1042, and as the District Court apparently agreed, these regulations do not resolve the challenged statutes' constitutional shortcomings, by reason of, *inter alia,* their inapplicability to minors under the age of 13 years, their failure to require a hearing within a reasonable time, and the absence of any provision for automatic appointment of an advocate to represent the child's interest. Several expert witnesses also expressed misgivings about the regulations promulgated by the state. In summary, they felt that the regulations did not ensure adequate evaluation of the child; that there was a tendency for psychiatrists to agree among themselves for reasons unrelated to the needs of the patient; that admitting psychiatrists to an institution may be unduly influenced by institutional demands; that once institutionalized, individuals tend to accede to the institution's point of view and in spite of the notice requirements, an individual may not be able to express his objections (A. 558, 561, 598, 628-629, 630-631). In any event, actions such as the promulgation of the above described regulations after the initiation of litigation do not moot the case even to the extent of such voluntary cessation or alteration of the challenged practices, for the obvious reason that the defendants-appellants would be free to return to their old ways absent judicial intervention. *United States* v. *W. T. Grant Company,* 345 U.S. 629, 632 (1952); *Walling* v. *Helmerich Payne, Inc.,* 323 U.S. 37 (1944); *United States* v. *Trans-Missouri Freight Association,* 166 U.S. 290, 309-310 (1897).

help of equally conscientious, dedicated state employed psychologists and social workers, faithfully care for the plaintiff children to the extent that state furnished resources and facilities permit. Nevertheless, psychiatry according to psychiatrists is still an inexact science as to which there is the opportunity for wide, sincere differences of opinion among psychiatrists. The opportunity for such wide differences of opinion stems initially and primarily from the fact that psychiatry is dependent upon information that comes from the patient and from other people—parents, family, and staff —who themselves have their own personal interests and problems in communication. To suggest, as we here do, that psychiatrists are not infallible is not an indictment of psychiatry. It is simply to say that psychiatrists like all humans are capable of erring. Since they are capable of erring, psychiatrists like parents cannot statutorily be given the power to confine a child in a mental hospital without procedural safeguards being imposed to guard against errors in judgment and/or the arbitrariness that the best of us humans exhibit from time to time. *J.L.* v. *Parham, supra,* 412 F.Supp. at 138. (Footnote omitted.)

Expert testimony at the trial corroborated the view that placing sole reliance on a psychiatric prognosis, without recourse to review by an unbiased tribunal, will not suffice to prevent unnecessary or inappropriate commitments (A. 550, 569, 585, 604).

**D. The Labeling of Juvenile Mental Disability Commitments As Civil (Rather Than Criminal), Benevolent, or Voluntary Does Not Affect the Applicability of the Due Process Clause.**

This Court has long avoided the labeling of a particular proceeding as "civil" rather than "criminal" and imposed due process requirements when it was



clear that the potential existed for serious deprivation of constitutionally protected interests. *E.g., Breed* v. *Jones,* 421 U.S. 519, 530 (1975); *In re Gault, supra; Specht* v. *Patterson, supra; cf. Heryford* v. *Parker, supra,* at 396. The same deprivations threatened in these prior juvenile and quasi-criminal "civil" proceedings are present here, and the same reasoning should apply. Similarly, this Court should affirm the District Court's emphatic rejection of the defendants' argument that the benevolent (habilitative or rehabilitative) purpose of juvenile mental disability commitments insulates them from due process requirements. See 402 F.Supp. at 1045 n.7 (and cases cited therein), 1046-1047. Finally, the statutory characterization of these admissions and commitments as "voluntary" should not mask the fact that they are voluntary on the part of the parent (or other person or agency seeking institutionalization), but not on the part of the child being deprived of his liberty. Thus the requirements of due process should apply.

**E. The Imposition of Due Process Protections Upon the Institutionalization Decision Is Necessitated Both by the Risk of Erroneous Psychiatric and Other Judgments and by the Need to Ensure That Less Restrictive Alternatives Are Adequately Explored.**

The deprivation and consequences of institutionalization described in the first section of this brief would, in themselves, require that institutionalization decisions made by or through the authority of the state be subject to the requirements of the due process clause. The special nature of the admission/commitment decision, however, demands the type of procedural safeguards mandated by the District Court for at least two further reasons—the uncertainty of psychiatric

(and other) diagnoses and the need, from both a professional and constitutional standpoint, to place an allegedly mentally disabled person in the least restrictive setting which will meet his treatment needs.

The Chief Justice has recently noted the "uncertainties" of diagnosis and therapy in the "baffling" field of psychiatry, and has observed, correctly, that "the reported cases are replete with evidence of the divergence of medical opinion in this vexing area." *O'Connor* v. *Donaldson,* 422 U.S. at 579 (Burger, C.J., concurring). This Court has previously remarked upon "the uncertainty of diagnosis in this field and the tentativeness of professional judgment." *Greenwood* v. *United States,* 350 U.S. 366, 375 (1956); *cf.* Ennis & Litwack, "Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom," 62 Calif. L. Rev. 693 (1974). Expert testimony in the instant case indicated that an admission/commitment hearing, or even the knowledge that a hearing may be requested, will encourage psychiatrists to exercise greater care in evaluating prospective patients and thus diminish the chance for an erroneous decision (A. 543-544, 640-641). The pendency of a hearing will also dilute the tendency of some psychiatrists to overdiagnose or to err on the side of caution, assuming disease over health. See Ellis, *supra,* 62 Calif. L.Rev. at 865; Rosenhan, "On Being Sane in Insane Places," 113 Santa Clara L. Rev. 379 (1973). Given the uncertainties in the field of mental disability, and the difficulty in relating psychiatric or psychological diagnoses to legal standards for commitment,[15] proper fact-finding procedures are a

[15] Shah, "Dangerousness: Some Definitional, Conceptual, and Public Policy Issues," in *Perspectives in Law and Psychology* (in press); "Some Interactions of Law and Mental Health in the Handling of Social Deviance," 23 Catholic U.L. Rev. 674 (1974).



practical and constitutional necessity in the civil commitment process.

Moreover, it is no longer open to serious question that state-imposed deprivation of personal liberty for purposes of mental disability treatment, or any other such incursion on constitutionally protected liberties, must be only to the limited extent necessary to accomplish the legitimate purpose of the deprivation or limitation in question. *Shelton* v. *Tucker,* 364 U.S. 479, 488-490 (1960). Numerous lower Federal courts have recognized the applicability of this "least restrictive alternative" doctrine to commitment and treatment of the mentally disabled. *New York State Association for Retarded Citizens and Parisi* v. *Carey, supra,* Order of April 30, 1975, Appendix A at 1; *Lynch* v. *Baxley, supra,* 386 F.Supp. at 392; *Welsch* v. *Likins, supra,* 373 F.Supp. at 501-502; *Lessard* v. *Schmidt, supra,* 349 F. Supp. at 1096; *Wyatt* v. *Stickney, supra,* 344 F.Supp. at 379, 396; *cf. Dixon* v. *Weinberger,* 405 F. Supp. 974 (D.D.C. 1975)[16]; *Covington* v. *Harris,* 419 F.2d 617 (D.C. Cir. 1969); *Lake* v. *Cameron,* 364 F.2d 657 (D.C. Cir. 1966). Indeed, this Court has specifically applied this rationale to mental disability commitments:

> May the State confine the mentally ill merely to ensure them a living standard superior to that they enjoy in the private community? That the State

[16] In this case, based on the 1964 Hospitalization of the Mentally Ill Act, 21 D.C. Code §§ 501 *ff.*, the District Court, in endorsing the least restrictive approach to both commitment and treatment, found, not only that some patients in the District of Columbia mental hospital could fare as well in the community, but also that the treatment needs of 43% of the patients *required* them to be in the community. 405 F.Supp. at 976.

> has a proper interest in providing care and assistance to the unfortunate goes without saying. But the mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution. Moreover, while the State may arguably confine a person to save him from harm, incarceration is rarely if ever a necessary condition for raising the living standards of those capable of surviving safely in freedom on their own or with the help of family or friends. See *Shelton* v. *Tucker,* 364 U.S. 479, 488-490. *O'Connor* v. *Donaldson, supra,* 422 U.S. at 575.

The expert testimony in this case (A. 476-77, 577, 619-621) and the professional literature [17] are in accord with the foregoing legal analysis. Thus perhaps the most vital function of procedures such as those required by the court below is to prod the parents, professionals, and others involved in the admission/commitment process to avoid unnecessary and inappropriate institutionalization and, if necessary, to invest the resources of other social agencies and the committing tribunal in identifying or creating treatment alternatives which will not unduly limit the personal freedom (or the therapeutic prognosis) of the individual facing commitment.

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[17] Glenn, *supra,* at 499-514; Wolfensberger, *The Principle of Normalization in Human Services* (1972); Joint Commission on Accreditation of Hospitals, *Accreditation Manual for Psychiatric Facilities Serving Children and Adolescents,* at 55 (1974). This legal and professional consensus is reflected in the Federal Medicaid regulations governing under-21 inpatient psychiatric services (45 C.F.R. § 249.10(b)(16)(iii), 41 F.R. 2198 (January 14, 1976)) and institutional care and treatment of the mentally retarded (45 C.F.R. § 249.13(a)(2)(iv), 39 F.R. 2220, 2227 (January 17, 1974)).



**3. No Justification Appears or Has Been Advanced for Denying to Children Facing Commitment on Mental Disability Grounds Substantially the Same Procedural Protections Which Are Required for Adults Under the Due Process Clause.**

As noted above, admission/commitment of children to mental institutions involves at least an equivalent degree of deprivations and risks, and is subject to the same possibility of erroneous or inappropriate diagnosis or placement decisions, as the involuntary commitment of adults. In the instant case, the only asserted basis for denying to such children the procedural protections due to adults relates to a somewhat vaguely defined state interest in preserving parental authority and family unity. While as the District Court noted, 402 F.Supp. at 1048 n.12, parents are often in the best position to assess a child's needs, their legitimate concerns can be accommodated without vesting them and state authorities with unfettered control over the institutionalization of children. The asserted state interest cannot justify the deprivation of children's personal liberty without due process of law.

**A. The Decisions of This Court Indicate That Parental Authority Is Not Without Limits, and That Children, As Well As Adults, Are Entitled to Constitutional Protections.**

This Court has been presented with numerous cases involving the issue of the scope and nature of parental authority in the upbringing of their children, and has generally accorded parents great leeway. *Wisconsin* v. *Yoder,* 406 U.S. 205 (1972); *Ginsberg* v. *New York,* 390 U.S. 629 (1968); *Pierce* v. *Society of Sisters,* 268 U.S. 510, 539 (1925); *Meyer* v. *Nebraska,* 262 U.S. 390 (1923). However, as important as the result in *Wisconsin* v. *Yoder, supra,* was its carefully circumscribed definition of parents' authority as related to denial of

their children's opportunity for a free, public secondary school education. *Id.* at 230-234.[18]

The parental authority recognized by this Court has never been absolute, and where a superseding state interest has been demonstrated, this Court has not hesitated to condone intrusion into the parent-child relationship, primarily in a situation where the child's welfare could be jeopardized:

> But the family itself is not beyond regulation in the public interest . . . . Acting to guard the general interest in youth's well being, the state as *parens patriae* may restrict the parent's control by requiring school attendance, regulating or prohibiting the child's labor and in many other ways. *Prince* v. *Massachusetts,* 321 U.S. 158, 166 (1944).

At the same time, this Court has recognized that minors are entitled to many of the same constitutional rights and protections that adults enjoy, *Tinker* v. *Des Moines Independent Community School District,* 393 U.S. 503 (1969), particularly with regard to procedural due process. Minors facing the possibility of institutionalization as a result of delinquent behavior have been accorded almost all the procedural safeguards of adult defendants. See *Breed* v. *Jones, supra; In re Winship, supra; In re Gault, supra.* Due process protections have even been accorded to students facing suspensions from school of ten days or less. *Goss* v. *Lopez,* 419 U.S. 565 (1975). Against this background, it would be anomalous to hold that procedural due process protections should not apply as well to indefinite commitment of minors to mental institutions.

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[18] Moreover, *Wisconsin* v. *Yoder* turned on First Amendment freedom of religion questions which have no parallel in the instant case.



**B. This Court's Recent Decisions With Regard to Abortion Reflect the Proper Balancing of Interests to Be Applied in the Instant Case.**

In *Planned Parenthood of Central Missouri* v. *Danforth,* —— U.S. —— (July 1, 1976), and *Bellotti* v. *Baird,* —— U.S. —— (July 1, 1976), this Court was confronted with the question, *inter alia,* of whether parents could constitutionally prevent their minor daughters from obtaining an abortion under circumstances in which, pursuant to *Roe* v. *Wade, supra,* an adult woman would have an absolute right to terminate an unwanted pregnancy.

"Constitutional rights," this Court observed, "do not mature and come into being magically only when one attains the state-defined age of majority. Minors, as well as adults, are protected by the Constitution and possess constitutional rights." *Planned Parenthood of Central Missouri* v. *Danforth, supra,* —— U.S. at ——. Given that in some instances, the state's authority to regulate children may be broader than its authority with respect to adults, the Court continued, it is necessary

> to examine whether there is any significant state interest in conditioning an abortion on the consent of a parent or person *in loco parentis* that is not present in the case of an adult.
>
> One suggested interest is the safeguarding of the family unit and of parental authority. [Citation omitted.] It is difficult, however, to conclude that providing a parent with absolute power to overrule a determination, made by the physician and his minor patient, to terminate the patient's pregnancy will serve to strengthen the family unit. Neither is it likely that such veto power will enhance parental authority or control where the

> minor and the nonconsenting parent are so fundamentally in conflict and the very existence of the pregnancy already has fractured the family structure. Any independent interest the parent may have in the termination of the minor daughter's pregnancy is no more weighty than the right of privacy of the competent minor mature enough to have become pregnant. *Planned Parenthood of Central Missouri* v. *Danforth, supra,* —— U.S. at ——.

The Court's holding in the *Planned Parenthood* case leads directly to the conclusion that the existence of a conflict between parent and child does not mean the constitutional rights of the child must inevitably give way. Certainly, a child's interest in avoiding a wrongful, inappropriate, and potentially life-long commitment to a mental institution is equivalent in gravity and importance to a minor's right to obtain an abortion, and the same balancing of interests is required. So examined, the child's interest in not being improperly institutionalized outweighs the parent's (or guardian's) interest in having absolute (or near-absolute) control over the commitment decision.

Moreover, if the state, *qua* state, cannot institutionalize an individual without proper procedural protections, such authority cannot constitutionally be delegated to a parent or other third party. *Planned Parenthood of Central Missouri* v. *Danforth, supra,* —— U.S. at ——.

**C. The District Court Properly Accommodated the Interests of the Parent and Child in Requiring Due Process Safeguards.**

It must be recalled that the District Court in the instant case did not exclude parents or guardians from participation in the institutionalization decision, but



merely interposed a set of procedural protections and an unbiased tribunal (not necessarily a court) as a check on parental (and professional) authority in this area:

> This finding does not mean that when considering whether or not to institutionalize a child, the state should ignore the opinions and observations of the child's parents. Rather the committing authorities should listen carefully to parents who live with and observe the child on a daily basis for they very likely have invaluable information concerning their child. 402 F.Supp. at 1048 n.12.

Such a holding is fully consistent with the balancing approach adopted by this Court in the above-cited abortion cases. Concurring in *Planned Parenthood of Central Missouri* v. *Danforth, supra,* Mr. Justice Stewart and Mr. Justice Powell indicated that the issue might have been different if, instead of a situation where the parent exercised absolute control over the child's decision, the Court were considering a "provision requiring parental consent or consultation in most cases but providing for prompt (i) judicial resolution of any disagreement between the parent and the minor, or (ii) judicial determination that the minor is mature enough to give an informed consent without parental concurrence or that abortion in any event is in the minor's best interest."

Such a provision, said the concurring opinion, "would not impose parental approval as an absolute condition upon the minor's right but would assure in most instances consultation between the parent and child." *Planned Parenthood of Central Missouri* v. *Danforth, supra,* —— U.S. at —— (Stewart and Pow-

ell, JJ., concurring); *cf. Bellotti* v. *Baird, supra,* —— U.S. at ——.

This Court's opinions thus contemplate that in situations such as the case at bar, an acceptable formulation can be achieved which allows for parental involvement to an appropriate extent while preserving the rights of the minor child involved, and which utilizes a neutral body to resolve these different and potentially conflicting interests. The order of the court below does no more and, indeed, could do no less.

**D. It Cannot Be Assumed That Parents, Faced With Legitimate Familial Problems, Will Always Act in the Best Interest of Their Children With Regard to Commitment to a Mental Institution.**

As found by the court below, parents (or guardians), even with the best of motives, may not act, or be capable of acting, in the best interest of their children in seeking their institutionalization. 402 F.Supp. at 1047. This does not mean that such parents are acting malevolently or punitively, although a small number may do so. What it does mean is that very often the child's problem is part of a larger familial problem, and that the entire family should be treated as a whole rather than isolating one member of the family in an institution. But familial problems may produce such a level of frustration and anxiety that parents are simply incapable of objectively considering the child's interests when they make the critical decision of institutionalization (A. 468, 471, 501, 589-590, 601, 617-618, 628).

In other words, minors are likely to suffer or be blamed for problems that plague the entire family and for situations that require help for the family as a



unit, not just for the child. See 402 F.Supp. at 1044; A. 472, 590, 617-618, 630. This being the case, the District Court rightly concluded, parents are in no position to waive a child's personal constitutional rights and make institutionalization decisions virtually on their own. 402 F.Supp. at 1047-1048.

Other courts have also recognized that a child's best interest is not always the motivating factor behind the institutionalization decision. See, *e.g., Heryford* v. *Parker, supra; J.L.* v. *Parham, supra,* 412 F.Supp. at 116-117; *Saville* v. *Treadway, supra,* 404 F.Supp. at 432; *Horacek* v. *Exon, supra,* Order of June 4, 1974; *New York State Association for Retarded Children and Parisi* v. *Rockefeller, supra,* 357 F.Supp. at 762; *In re Long,* 214 S.E.2d 626 (N.C. 1975). As the Chief Justice put it several years ago,

> [l]awmakers in recent years have been sensitive to the need to make civil commitment difficult, recognizing the dangers of relatives "farming" out their kindred into mental institutions for motives not always worthy. *Kent* v. *United States,* 401 F.2d 408, 416 n.4 (1968) (Burger, J., dissenting).

Children, especially those who cannot speak for themselves, must be protected from the risk of such inappropriate and harmful decisions.

**E. Claims of Alleged Traumatizing or Disruptive Effects of Due Process Protections for Children Are Not Supported by the Record.**

Defendants-appellants contend that a due process hearing prior to institutionalization will have a traumatizing effect on the child or divide and disrupt the family involved. However, in proceedings below, sev-

eral experts testified that a hearing may be beneficial for both parent and child. Properly administered, a hearing can impart to the child a sense that he is being dealt with fairly. A hearing may also help to relieve parents' anxiety or guilt by removing from them the necessity of making the final decision (A. 480-481, 483, 494-495, 574-578, 597, 623-624).[19] Even assuming some unpleasantness or familial discord, it is hard to conceive of these effects as more traumatizing than the effects of indefinite commitment, especially if the institutionalization turns out to be inappropriate or unnecessary. Further, there may be cases where there is little or no family harmony left to preserve and where a hearing will hardly make matters worse (A. 571-572). See the above quoted passage from *Planned Parenthood of Central Missouri* v. *Danforth, supra,* —— U.S. at ——.

Thus the reasons advanced for preserving a system in which the child's interests are not assured of representation cannot be supported on the basis of the record in this case, and, even on their face, do not justify the risk of inappropriate or unnecessary institutionalization.

[19] It should be remembered, again, that a formal hearing will not necessarily be held in every case as a result of the District Court's decision.



## CONCLUSION

For the reasons set forth above, the American Bar Association urges this Court to affirm the judgment and decree of the District Court.

Respectfully submitted,

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August, 1976

# APPENDIX

## APPENDIX

### ABA Commission on Standards of Judicial Administration

*Standards Relating to Trial Courts.**

2.72 PROCEEDINGS CONCERNING INVOLUNTARY CARE AND TREATMENT.

In civil proceedings for commitment of the mentally ill, and in all other proceedings in which a disposition of a person may be made on account of his mental or physical condition, the court should ensure that the disposition is made on the basis of adequate information, in accordance with applicable law, and with due regard for the rights of the individual and of the public.

(a) *Procedural Requirements.*

(1) The person who is subject to the proceeding and his family or others immediately concerned for his welfare should be given adequate notice and an opportunity to be heard.

(2) The court should formulate clearly the issues to be resolved, with particular regard for the matters to be considered in the course of medical, psychological, or psychiatric examination and to be made the subject of expert testimony.

(3) Clinical evaluation should be made by professionally qualified persons on the basis of examination and other diagnostic procedures that conform to professionally recognized standards. The person who is the subject of the proceeding should be entitled to obtain and present such an evaluation on his own behalf, at public expense if he lacks the means to obtain it himself. Examiners should be required to testify as to the extent of their examination and the grounds for their conclusions. Except on stipulation of both parties, the testimony of all witnesses, includ-

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* Based on draft approved at February, 1976, mid-year meeting.

ing expert witnesses, should be presented in open court, subject to cross-examination, and included in the record of the proceeding.

(4) The person subject to the proceeding should be entitled to the assistance of counsel as provided in Section 2.20.

(5) In exercising its power to order care and treatment, the court should consider possible alternative dispositions, imposing only as much restraint as is necessary for protection of the individual, his family, or the public, or for accomplishment of required treatment.

(6) When commitment is ordered, the court should specify its purposes, the terms and conditions of any custody or restraint that may be directed, and a time limit, upon the expiration of which the matter is to be brought before the court for further consideration unless the person has been discharged prior to that time according to law.

(7) Whenever a person is found to be mentally ill or mentally retarded or is committed to an institution where he may be unable to take an active part in management of his property or business interests, and it appears that the commitment may be of long duration, the court should inquire into the nature of such interests and the possibility that guardianship of his property or like safeguards should be established to protect them.

(8) Observational commitments. Involuntary commitments for the purposes of observing the individual's mental or physical condition should be to the least restrictive environment in which the observation can be conducted and only for that period of time which is reasonably necessary to complete such observation.

(9) Emergency commitments. Emergency commitments without judicial proceedings should be permitted only in cases of extreme physical danger to human life, health, or safety, and should not be continued beyond the



time reasonably necessary to arrange for a preliminary hearing before a judge.

(b) *Staff Assistance.* The court should have sufficient supporting staff and access to psychiatrists and other professionally qualified experts to carry out its responsibilities under this Section.

COMMENTARY

In recent years the traditional procedures for civil commitment of the mentally impaired, and procedures involving defendants in criminal cases who plead insanity or whose competence to stand trial is in question, have been augmented by an array of statutory procedures for commitment of narcotics addicts, alcoholics, and persons manifesting such types of statutorily defined social deviance as "sexual psychopathy" and "defective delinquency." Because these proceedings are generally termed civil rather than criminal, even when they arise out of criminal prosecution, fewer procedural protections are generally afforded the persons subject to them. The distinction between civil and criminal in many of these cases, however, is more apparent than real. Commitment to an institution on the ground of mental or physical condition is a deprivation of liberty and has many of the characteristics of penal sanctions: confinement (often under harsh conditions), isolation from family and friends, inability to earn a living, persisting social stigma, and sometimes loss of civil and professional rights. Like criminal prosecution, it is often the result of an alleged offense against the law or mores of the community. Procedural safeguards in these cases should not depend on mechanical application of a dichotomy between civil and criminal procedures.

The role of the court in commitment and related procedures should be clearly understood as including responsibility for determining the legal and factual issues that may be presented. The court should not simply ratify recommendations of medical examiners on the assumption that

the question is one of medical diagnosis. Statutory definitions of the classes of persons subject to these proceedings do not necessarily correspond to any generally accepted medical diagnostic category. Moreover, psychiatric diagnosis by one diagnostician may differ greatly from that by another who is equally well qualified, and may sometimes be influenced by irrelevant or insubstantial therapeutic, social, or institutional considerations. The lack of precise criteria for determining the potential dangerousness of an individual should be taken into account, as should the tendency of medical witnesses to overpredict dangerous behavior. The medical expert must provide the court with the medical facts and medical opinions essential to a decision, including diagnosis, prognosis, suitability of proposed treatment, prospect of improvement under possible alternative dispositions, and the like. However, the ultimate decision is not essentially a medical one and involves a substantial element of legal discretion. The special problems encountered in these cases make it desirable that judges have been prepared by experience or training for their role. [Reference omitted.]

Notice and an opportunity to be heard should be provided even though the person subject to the proceeding appears to be mentally incapable of acting upon them. Notice may be delivered by a social worker or other trained person acting on behalf of the court who can explain its meaning and offer assistance in obtaining counsel and making preparations for the hearing. Notice of the hearing should also be given to relatives or friends who may assist the respondent or act in his behalf. Notice should be given sufficiently in advance of scheduled court proceedings to afford a reasonable opportunity for preparation, and should inform the person with particularity of the basis for his detention, his right to counsel and to trial by jury (where available) and the standard upon which he may be detained.



The person who is subject to commitment should be personally present, except where the court finds that he is incapable of attending the hearing or that attending the hearing would worsen his condition or might incite him to injure someone else as a result of hearing the testimony. He should in any event be represented by counsel. See Section 2.20.

Where the respondent is in such a condition that he cannot be present at the hearing, a conference with the judge may allow him to state his case without being required to be present at the formal hearing, but such a conference should not take the place of an evidentiary hearing. Disposition should be made only upon a hearing at which medical and other witnesses are present and subject to cross-examination by counsel and questioning by the court unless the parties agree to presentation on the basis of written documents. Hearings should be on a formal record and decisions based on written findings of facts.

Hearings under sex-psychopath and similar quasi-criminal statutes should provide all the procedural safeguards of a criminal trial. In cases where determination of mental condition is related to criminal proceedings, a separate hearing should be held on mental condition, with adequate notice to the defendant of the questions at issue and the possible consequences of the determination.

The usefulness of medical reports and testimony can often be greatly improved if the court advises examiners and witnesses in advance of the kinds of information it requires for an informed decision. This can be done through examination forms stating the legal questions before the court (for example, whether the individual is competent to stand trial), and indicating the facts required for a finding on the question at issue (for example, whether he could cooperate with counsel in his own defense). Examiners should be required to state the nature and extent of their

examination and the grounds on which they base their findings and conclusions.

Counsel for the respondent should be afforded sufficient time and resources to consult with his client, secure independent professional examination if desired, and inform himself about possible alternatives to commitment. Special training for counsel in mental illness cases can be helpful in improving the quality of representation.

In reaching a disposition, courts should consider all reasonable alternatives such as voluntary hospitalization and treatment in the community without full-time hospitalization. Dispositions should provide for the minimum amount of restraint consistent with accomplishing the purposes of the law.

Commitments should be limited to a relatively short period, at the end of which the necessity of further commitment should be judicially determined. Periodic review of the status of committed persons should be initiated by the court unless a public guardian or defender agency can assume responsibility for doing so. The review should involve notice and formal hearing, with the respondent represented by counsel and medical witnesses subject to cross-examination as in the original commitment proceeding. All reasonable alternatives to commitment should again be considered, and a realistic assessment made of the likelihood of accomplishing further therapeutic objectives by commitment.

Supreme Court, U. S.
FILED
AUG 12 1976

IN THE

# Supreme Court of the United States

OCTOBER TERM, 1976

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**No. 75-1084**

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JACK B. KREMENS, et al., *Appellants,*

v.

KEVIN BARTLEY, et al., *Appellees.*

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**On Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania**

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**BRIEF FOR THE PLAINTIFFS IN POE, ET AL. v. MATHEWS, ET AL. (D.D.C. NO. 74-1800); J. L. ET AL. v. PARHAM, ET AL. (M.D. GA. NO. 75-163-MAC), APPEAL DOCKETED (NO. 75-1690, MAY 21, 1976); MARTIN M., ET AL. v. SHEPHARD, ET AL. (D. CONN. NO. H-75-130); AND D. L. K., ET AL. v. STUBBS, ET AL. (S.D. MISS. NO. J76-3(C)) AS AMICI CURIAE**

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IN THE

# Supreme Court of the United States

OCTOBER TERM, 1976

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No. 75-1064

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JACK B. KREMENS, et al., *Appellants,*

v.

KEVIN BARTLEY, et al., *Appellees.*

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**On Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania**

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**BRIEF FOR THE PLAINTIFFS IN POE, ET AL. v. MATHEWS, ET AL. (D.D.C. NO. 74-1800); J. L., ET AL. v. PARHAM, ET AL. (M.D. GA. NO. 75-163-MAC), APPEAL DOCKETED (NO. 75-1690, MAY 21, 1976); MARTIN M., ET AL. v. SHEPHARD, ET AL. (D. CONN. NO. H-75-130); AND D. L. K., ET AL. v. STUBBS, ET AL. (S.D. MISS. NO. J76-8(C)) AS AMICI CURIAE**

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This brief amici curiae is filed by the plaintiffs in *Poe, et al.* v. *Mathews, et al.* (D.D.C. No. 74-1800); *J.L., et al.* v. *Parham, et al.*, 412 F. Supp. 112 (M.D. Ga. 1976), *appeal docketed*, No. 75-1690 (May 21, 1976); *Martin M., et al.* v. *Shephard, et al.* (D. Conn. No. H-75-130; and *D.L.K., et al.* v. *Stubbs, et al.* (S.D. Miss. No. J76-8(C)), with the consent of the parties herein, in accordance with Rule 42 of the Rules of this Court.

## INTEREST OF THE AMICI CURIAE

Amici are children who were committed to state mental institutions by their parents or custodians without

being afforded the right to an evidentiary hearing. They are the plaintiffs in four cases pending in the lower federal courts, or on appeal to this Court, which challenge the procedures by which they were committed; that is, whether a state can commit a child to a mental institution without affording him an evidentiary hearing upon the consent of the child's parents, guardian or custodian.[1]

This brief is filed because the issues involved in this appeal overlap those presented in the cases in which amici are plaintiffs, and the resolution of these issues

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[1] Plaintiff in *Poe* v. *Mathews, supra,* represent a class of "persons under the age of 18 years who have been committed to St. Elizabeths Hospital against their will at the request of their parents or guardians pursuant to D.C. CODE §§ 21-511 and 512." Order, March 25, 1975. Proceedings in *Poe* have been stayed pending this Court's decision in the instant case. Order, March 5, 1976.

Plaintiffs in *J.L.* v. *Parham, supra,* represent persons younger than 18 years of age who have been detained at mental institutions within the state of Georgia pursuant to GA. CODE ANN. § 88.503.1. On February 26, 1976, the United States District Court for the Middle District of Georgia held that statute to be unconstitutional on the ground that it did not provide juveniles with hearing rights and entered appropriate relief. 412 F. Supp. at 139-40. The order of the three-judge court was stayed by this Court on April 5, 1976. 425 U.S. ——, 96 S. Ct. 1503. An appeal from the district court's decision was docketed on May 21, 1976.

Plaintiffs in *Martin M.* v. *Shephard, supra,* represent persons under the age of 16 years who are or may be confined against their will at the request of their parents or guardians at any state mental institution pursuant to CONN. GEN. STAT. § 17-187 as limited by § 17-206a(d). Order, Dec. 5, 1975. The case is in the discovery stage.

Plaintiffs in *D.L.K.* v. *STUBBS, supra,* are unmarried persons under the age of 18 years who have been committed to Mississippi mental institutions against their will at the request of their parents or guardians pursuant to MISS. CODE ANN. § 41-21-103-2(c). This case is also in the discovery stage.



in this case may control the decisions in these other cases. Amici argue herein that, because of the revision of Pennsylvania's statutory procedures for the commitment of children that occurred in July, 1976, after the decision of the district court, this appeal should not be decided on the merits. Amici believe that a decision should not be rendered on the merits, because, for reasons set forth below, the statutory changes destroy that "adverse concreteness" which is necessary for the proper and informed decision of important constitutional issues.

In the event that the Court reaches the merits, however, this brief sets forth amici's position with respect to the underlying question of whether due process guarantees a child the right to an evidentiary hearing in connection with civil commitment to a mental institution, despite the consent or acquiescence of his parent or custodian. In the course of this brief, amici will bring to the Court's attention factual material, developed through the discovery process and trial of their respective cases, concerning the impact of mental institutionalization upon children and the operation of juvenile commitment schemes.[2] This additional information will give the Court a broader basis upon which to decide the important constitutional questions raised by this appeal.[3]

---

[2] Amici will lodge with the Clerk of this Court the materials cited from the records in their cases shortly after filing this brief.

[3] This brief will not address the question of the procedures required to commit juveniles to facilities for the mentally retarded. Amici were all commiteed to mental institutions on the ground that they were mentally ill, and the cases they have brought challenge only such commitments.

## QUESTIONS PRESENTED

1. Does this Court have jurisdiction over the appeal, and if so, should such jurisdiction be exercised in light of the intervening change in the Pennsylvania statutes challenged by appellees?

2. Does the Due Process Clause of the Fourteenth Amendment guarantee a juvenile the right an an evidentiary hearing and access to counsel in connection with his commitment to a mental institution, regardless of the concurrence of his parent or custodian in the commitment decision?

## FACTUAL STATEMENT

### A. COMMITMENT PROCEDURES IN THE STATES WHERE AMICI ARE CONFINED AND THOSE GENERALLY IN EFFECT

The statutes of every state and the District of Columbia authorize commitment of persons to mental institutions.[4] In most states, and in each of the states in which amici reside, there are two procedures for the commitment of adults. An adult may be committed without a court order if he applies to a mental institution under a voluntary commitment statute.[5] Gen-

[4] For a list of citations to the commitment statutes *see Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1203-04 nn. 11-14 (1974) and Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 CALIF. L. REV. 840 n. 1 (1974).

[5] *See, e.g.*, CONN. GEN. STAT. § 17-187 as modified by § 17-206a (d); D.C. CODE § 21-511 to -512; GA. CODE ANN. § 88-503; MISS. CODE ANN. § 41-21-103. The District of Columbia also permits admission without a hearing when a relative applies for the commitment and the person consents in writing; however, the person must be released immediately upon request. D.C. CODE §§ 21-513 to -514.



erally, the only check on the appropriateness of the commitment is the institution's agreement that the applicant needs treatment. Once committed, however, the individual is free to leave the institution upon request, unless involuntary commitment proceedings are initiated within a specified period after the request.[6]

On the other hand, if the adult does not apply for admission to a mental institution, the state or another third party must petition for an involuntary commitment order.[7] Under the involuntary schemes of virtually all states, including those in which amici reside, an adult cannot be committed without the opportunity to contest the petition in an evidentiary hearing.[8] The timing of the hearing depends on whether or not the individual's condition is alleged to necessitate immediate commitment. If immediate commitment is requested, the commitment is termed an emergency com-

[6] *See* CONN. GEN. STAT. § 17-187 (10 days; if the admission was "informal," he must be released immediately); D.C. CODE § 21-512 (2 days); GA. CODE ANN. § 88-503.3(a) (5 days, not including Saturdays, Sundays and holidays); MISS. CODE ANN. § 41-21-103(3) (5 days, not including Saturdays, Sundays and holidays).

[7] *See, e.g.*, CONN GEN. STAT. §§ 17-177 to -183; D.C. CODE §§ 21-541 to -545; GA. CODE ANN. §§ 88-504 to -508; MISS. CODE ANN. §§ 41-21-61 to -99.

[8] The right to a hearing in these states generally means the right to adequate notice; to counsel, appointed if the individual is indigent; to present evidence and confront and cross-examine witnesses; and to a decision by an impartial tribunal based solely on the evidence adduced at the hearing. *See* CONN. GEN. STAT. §§ 17-177 to -183; D.C. CODE §§ 21-541 to -545; GA. CODE ANN. §§ 88-507 to -508; MISS. CODE ANN. §§ 41-21-73 to -79. Throughout this brief, "evidentiary hearing" is used to refer to a hearing containing these safeguards.

mitment,[9] and the hearing occurs after the person has been institutionalized.[10] In a non-crisis case, the hearing must precede the commitment.[11]

Children are subject to both the voluntary and involuntary commitment schemes. In most states, however, it is the parent or custodian of the juvenile, rather than the child himself, who has the statutory authority to consent or object to commitment. If the parent or custodian objects to institutionalization, an evidentiary hearing is held under the involuntary procedure.[12] But if the parent or custodian applies for or consents to institutionalization, the commitment is considered "voluntary" and is made without a hearing, even over the child's protests.[13] In that circumstance,

[9] Emergency commitment standards frequently require an allegation not only that the person is mentally ill but also that he poses an immediate threat to himself or others. *See* CONN. GEN. STAT. § 17-183 ("suddenly becomes in need of care or treatment in a hospital for mental illness . . . [and] a danger to himself or others"); D.C. CODE § 21-521 ("likely to injure himself or others if not immediately detained"); Laws of 1976, ch. 401 § 2 (to be codified as MISS. CODE ANN. § 41-21-71(2)) ("substantial risk of imminent physical harm to himself . . . or . . . other persons"); *but cf.* GA. CODE ANN. § 88-504.2 ("mentally ill and likely to inqure himself or others").

[10] *See* CONN. GEN. STAT. § 17-183; D.C. CODE §§ 21-521 to -527; GA. CODE ANN. § 88-504; MISS. CODE ANN. §§ 41-21-71 to -83.

[11] *See* CONN. GEN. STAT. § 17-178; D.C. CODE §§ 21-541 to -545; GA. CODE ANN. § 88-507; MISS. CODE ANN. § 41-21-71(2).

[12] *See* statutes cited in note 7, *supra*.

[13] Consent to the juvenile's institutionalization need not be made by a parent or guardian. In Pennsylvania, for example, anyone acting "in loco parentis" may give such consent. 50 PA. STAT. ANN. § 4403(a)(2); *see also* statutes cited in note 3, *supra*. Thus, in the case of a juvenile who is in the custody of the state welfare department, the consenting party may be the state itself. In Connecticut, however, a superior court has held that a juvenile cannot be committed to a state mental institution by the state welfare department without prior judicial approval. *Sims* v. *Arafeh* (No. 24259, June 23, 1975).



the parent or custodian—but not the child—has the power to terminate the commitment.

### B. COMMITMENT PROCEDURES IN PENNSYLVANIA

#### 1. The Statutory Procedure When the Suit Was Filed

When the instant case was filed,[14] Pennsylvania commitment procedures paralleled those described above.[15] A person 18 years of age or younger could be committed to an institution for the mentally ill or mentally retarded without an evidentiary hearing if one of his parents, or a person standing in loco parentis to him, signed an application to an institution, and the director of the institution, after examination, agreed that the child was "in need of care or observation." 50 PA. STAT. ANN. § 4403(b).

The named plaintiffs were each committed to Haverford State Hospital, a state mental institution, upon consent of their parents, without an evidentiary hearing, when they were between the ages of fourteen and seventeen. A. 788-89. Plaintiffs filed this suit on behalf of all children committed to facilities for the mentally ill or mentally retarded alleging that the commitment of juveniles without an evidentiary hearing, under the voluntary scheme, 50 PA. STAT. ANN. §§ 4402 and 4403, violates due process.

[14] November 16, 1972. Joint Appendix 1. (Hereafter, "A. ——.")

[15] For the entire Pennsylvania state statutory scheme operative at the time of the lower court's decision, *see* 50 PA. STAT. ANN. §§ 4402-06.

### 2. The Procedures Under the Regulations Issued Prior to the Judgment Below

On September 1, 1973—after the suit was initiated, but before the trial was held—Pennsylvania's procedures for commitment of juveniles were altered by regulgation. A. 786-788 n. 5. The regulations provide that children 13 years of age or older, who are committed under the "voluntary" procedure, must be informed of their rights within 24 hours, including the right of access to counsel. If such a child objects to his confinement, he must be released within 48 hours, unless a petition for an involuntary commitment is filed within that period. If a petition is filed, the child remains in the institution pending the hearing. The regulations do not set a specific time period in which the hearing must be held. The regulations do not afford any evidentiary hearing rights, or other additional rights, to children less than 13 years old.[16]

### 3. The Procedures Under the Statute Enacted After the Entry of the Judgment Below

On July 9, 1976, after this Court noted probable jurisdiction of the appeal of the district court's order, the Pennsylvania legislature significantly revised its entire civil commitment law. Act No. 143, S.B. No. 1025. Two changes are of especial importance to this Court's deliberations. First, the new law provides that children

[16] The regulations also provide that a juvenile may be committed to a mental institution only if he is referred to the institution by a "recognized medical facility Mental Health/Mental Retardation therapist or Mental Health Agency", and the referral is accompanied by a psychiatric evaluation and a report recommending his institutionalization. This is in addition to the pre-existing requirements of parental or custodial consent, and approval of the director of the institution. *Id.*



fourteen years of age or older cannot be voluntarily committed to a mental institution by their parents or guardians. *Id.* § 201. Second, although a child less than fourteen years of age may still be committed by his "parent, guardian, or person standing in loco parentis," (*id.*), "any responsible party" who believes that it would be in the child's interest to be withdrawn from the institution or provided treatment in a less restrictive setting may petition the juvenile division of the court of common pleas for the county of the juvenile's residence. The court must then appoint counsel for the child and conduct a hearing within ten days to determine "what inpatient treatment, if any, is in the minor's best interest." *Id.* § 206(b).[17]

The status of the September 1, 1973 regulations as they pertain to mentally ill youths is unclear. Amici assume they remain in effect insofar as they do not conflict with the new law.

## C. THE DECISION BELOW

The three-judge district court, in an opinion dated July 24, 1975, held that the Pennsylvania juvenile commitment statutes, §§ 4402 and 4403, were violative of due process because of their failure to afford children the right to an evidentiary hearing in connection with their confinement in an institution for the mentally ill or the mentally retarded. The court found that the state regulations failed to cure the due process objections to the statutory procedures because (1) the regulations place the burden on the child to contact counsel and to

[17] The new Pennsylvania legislation makes no change in the procedure for the institutionalization of mentally retarded children. *Id.* § 507(a).

object to commitment, (2) they set no limit on the time a child may be confined after his objection and pending a hearing, and (3) the regulations have no applicability to children under thirteen. A. 786-88 n. 5.

The district court issued an injunction requiring that children whose commitment is sought be afforded basic procedural rights, including automatic access to counsel and the right to an evidentiary hearing, which cannot be waived by their parents.[18] Under the court's order, whenever the parent or custodian seeks a child's commitment, independent counsel must be appointed for the child. The child may waive his hearing rights and voluntarily accept institutionalization, but only

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[18] The court required these procedures:

(1) a probable cause hearing before an impartial officer within seventy-two (72) hours from the date of initial detention;

(2) a post-commitment hearing before an impartial hearing officer within two (2) weeks from the date of initial detention;

(3) written notice, including the date, time, and place of the hearing, and a statement of the grounds for the proposed commitment;

(4) counsel at all significant stages of the commitment process and, if the child is indigent, appointment of free counsel;

(5) the right of the child to be present at all hearings concerning his proposed commitment;

(6) a finding by clear and convincing proof that the child is in need of institutionalization;

(7) the right of the child to confront and to cross-examine witnesses against him, to offer evidence in his own behalf, and to offer testimony of witnesses.

A. 810-11.



with the approval of his attorney and the hearing officer.[19]

The State of Pennsylvania appealed and moved this Court for a stay of the district court's order. The stay was granted on December 16, 1975. 423 U.S. 1028. Probable jurisdiction was noted on March 22, 1976. 424 U.S. ——, 96 S. Ct. 1457.

## SUMMARY OF ARGUMENT

The Court should not reach the merits of this appeal because of the enactment of Act No. 143, S.B. 1025 by the State of Pennsylvania on July 9, 1976. This new statute accords the named plaintiffs all of the individual relief which they have sought in this litigation. Despite the class certification, the case is moot and plaintiffs lack standing because plaintiffs were not, at the time of their commitment or at the time of class certification, among the group of persons whose parents retain any control over the commitment decision under the new Pennsylvania law, *i.e.*, children under fourteen years of age. *See Hall* v. *Beals*, 396 U.S. 45 (1969).

Even if the disposition of this appeal were not controlled by the mootness and standing doctrines, the constitutionality of the new Pennsylvania statute

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[19] [E]xcepting the right to notice and counsel any or all of these rights may be waived by the child and the unbiased tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them. Because there may be situations when the child either does not understand his rights or is not competent to waive them, any or all of these rights may also be waived by the child's attorney and the unbiased tribunal may accept the waiver upon a finding that the waiver is appropriate.

A. 811 n. 26.

should not be reviewed by this Court prior to a decision on this question by the district court. Indeed, the district court expressly left open to the state the option of revising its own procedures, in a manner consistent with due process, as an alternative to the procedures it ordered. The district court's judgment as to whether the new statute satisfies due process requirements should precede a judgment by this Court.

If the Court determines to reach the merits, its decision should sustain the principle that due process requires access to counsel and the right an an evidentiary hearing in connection with the commitment of a child to a mental institution, and that these safeguards may not be waived by a parent of custodian. An erroneous commitment to a mental institution imposes very substantial harm on a child both by the very nature of institutionalization and because of the harmful conditions that exist in many mental institutions in this country. The risk of error in psychiatric recommendations to commit a child are high. Decisions to commit children are frequently made hurriedly and with very little information. Institutional psychiatrists have a strong predisposition to recommend commitment in doubtful cases, and this tendency exacerbates the general unreliability of psychiatric diagnoses. The risk of error can be substantially reduced by the participation of counsel and a full evidentiary hearing. The burden involved would not be substantial and might very well be offset by cost savings resulting from the elimination of unnecessary inpatient treatment.

There are strong reasons not to permit a parent or custodian to waive the child's due process rights. In many instances, commitment of a child is sought by a welfare agency standing "in loco parentis", although



the agency has little real connection with the child. Nor does the consent of a natural parent protect against serious error. Even when a parent is acting in the best of faith, his decision may be the product of great stress, acquiescence in the recommendation of the institutional psychiatrist, or lack of knowledge of the availability of less restrictive treatment alternatives. And in some cases, the interests of the parent will be in conflict with those of the child. The parent may simply not want to live with a difficult child; or commitment of the child may serve to deflect attention from broader mental health problems of the family as a whole.

## ARGUMENT

### I.

### THE COURT SHOULD NOT REACH THE MERITS OF THIS APPEAL

The enactment of Act No. 143, S.B. 1025 by the State of Pennsylvania on July 9, 1976 is a fundamental change in circumstance, dictating that this appeal *not* be decided on the merits.

#### A. Plaintiffs' Individual Claims Are Now Moot, and Plaintiffs Lack Standing to Represent Those Children Who Continue to Have a Live Controversy With Defendants

All of the plaintiffs in this suit were over fourteen years of age when they were committed to a mental institution under the challenged statute, 50 PA. STAT. ANN. §§ 4402-03. The statute has now been amended to provide that children fourteen years and older cannot be committed against their will without a full evidentiary hearing. Act No. 143, S.B. 1025, §§ 201-206 (July 9, 1976).

It is settled that the appeal must be decided in light of the new statute. *Fusari* v. *Steinberg,* 419 U.S. 379, 387 (1974); *Allee* v. *Medrano,* 416 U.S. 802, 819-20 (1974); *California Bankers Association* v. *Shultz,* 416 U.S. 21, 49 n.21, 53 (1974); *Diffenderfer* v. *Central Baptist Church,* 404 U.S. 412, 414 (1972); *Hall* v. *Beals,* 396 U.S. 45, 48 (1969). This statute has granted plaintiffs all of the individual relief they sought in the courts. Thus, with respect to their individual claims, the case is moot for want of a present controversy. *Board of School Commissioners* v. *Jacobs,* 420 U.S. 148 (1975); *cf. Johnson* v. *N.Y. State Board of Education,* 409 U.S. 259 (1972).

In the circumstances of this case, class certification does not alter the conclusion of mootness. It is axiomatic that plaintiffs "cannot represent a class to which they do not belong." *Rosario* v. *Rockefeller,* 410 U.S. 752, 759 n.9 (1973); *Bailey* v. *Patterson,* 369 U.S. 31, 32-33 (1962). The district court certified a class of

> all children eighteen years of age or younger who have been, are, or may be admitted or committed to mental health or mental retardation facilities in Pennsylvania under the Pennsylvania Mental Health and Mental Retardation Act of 1966.

A. 844. However, by enacting Act No. 143 after the district court's judgment, the Pe. nsylvania legislature has drawn a sharp line between the various members of plaintiffs' original class.

Unlike the situation prior to the statutory change, the only children who can now be committed without an evidentiary hearing are allegedly mentally ill children under 14 and children who are allegedly mentally retarded. Therefore, only they continue to have a live controversy with defendants. Since plaintiffs were not



members of either of these groups at the time of their commitment, they lack standing to represent them now.

The situation mirrors that presented in *Hall* v. *Beals, supra.* There, suit challenging Colorado's six-month residency requirement for voting was instituted by persons who were denied the right to vote because they had resided in the state for only five months. The case was certified as a class action. By the time the case reached this Court, Colorado had enacted legislation reducing the requirement from six to two months. This Court held that the case was moot.

> . . . [T]he appellants' opposition to residency requirements in general cannot alter the fact that so far as they are concerned nothing in the Colorado legislative scheme as now written adversely affects either their present interests, or their interests at the time this litigation was commenced. Nor does the result differ because the appellants denominated their suit a class action on behalf of disenfranchised voters. The appellants "cannot represent a class of [which] they are not a part,"—that is the class of voters disqualified in Colorado by virtue of the new two-month requirement, a class of which the appellants have never been members.

396 U.S. at 48-49. (Citations omitted.)

The instant case is unlike *Sosna* v. *Iowa,* 419 U.S. 393 (1975) and *Franks* v. *Bowman Transportation Co.,* 424 U.S. ——, 96 S.Ct. 1251 (1976), where plaintiffs whose individual claims had become moot were allowed to continue to represent a class. The crucial distinction is that, at the time of this Court's decisions in both *Sosna* and *Franks,* the members of the class who continued to have a live controversy with the defendants were in the same position that the named plaintiffs

were in as of the dates those suits were filed and the classes certified. In the case *sub judice,* however, plaintiffs were never members of the class which continues to have a live controversy with defendants.

The record in the court below did not focus on the questions presented by the new statute with regard to the commitment of children in this more limited class. It did not in any respect address the problems involved in utilizing a different commitment scheme for mentally retarded children and mentally ill children below 14 than for mentally ill children over the age of 14. For these additional reasons, there is now missing with respect to these questions that "concrete adverseness which sharpens the presentation of issues, upon which the court so largely depends for illumination of difficult constitutional questions." *Baker* v. *Carr,* 369 U.S. 186, 204 (1962). The judgment of the district court should be vacated and the case dismissed as moot.

**B. The New Statute Should Not Be Reviewed Without a Decision as to Its Constitutionality by the District Court**

This Court has declined to decide constitutional issues unless they are presented "in clear-cut and concrete form" (*Rescue Army* v. *Municipal Court,* 331 U.S. 549, 584 (1947)), on a record adequate to permit an informed decision. *Storer* v. *Brown,* 415 U.S. 724, 739-40 (1974); *Cowgill* v. *California,* 396 U.S. 371 (1970) (Harlan, J., concurring); *International Brotherhood of Teamsters* v. *Denver Milk Producers, Inc.,* 334 U.S. 809 (1948).

In *Fusari* v. *Steinberg,* 419 U.S. 379 (1975), for example, a three-judge court determined that Connecticut's procedures for assessing a recipient's continued eligibility for unemployment benefits violated due



process guarantees. Subsequent to the lower court's decision, the Connecticut legislature enacted a new law revising the applicable procedures. Noting that the change in state law might "alter significantly the character of the system considered by the District Court," the Court held that it would be inappropriate to decide the issues presented. 419 U.S. at 380. The judgment was vacated and the case remanded to the district court for reconsideration in light of the new law.

The same action would be appropriate here. The adequacy of the new procedures to assure constitutional rights has never been considered by the district court. There is no record on this question. In its order, the district court explicitly left open to the state the option of devising its own procedures, consistent with due process rights:

> Our action is not intended to pre-empt the state which is free to develop its own safeguards so long as they are as fully effective as those which we set out.

A. 800 n. 16.

If this appeal is not disposed of on grounds of mootness or standing, the Court should vacate the district court's order and remand the case to the district court to hear evidence concerning the efficacy of the new system and to reconsider its judgment in light of the statutory changes.

**C. The Constitutionality of Commitment Procedures for Children Is Raised in Another Case Presently Pending on the Appeal Docket of the Court**

In considering whether to reach the merits of this appeal, it may be relevant to note that the constitu-

tional questions raised by commitment procedures which permit a parent or custodian to authorize the commitment of a child over his objection and without a hearing are squarely presented in *J. L.* v. *Parham,* 412 F.Supp. 112 (M.D.Ga. 1976), *appeal docketed,* No. 75-1690 (May 21, 1976).[20] The *J. L.* case involves none of the procedural problems that obscure the issues raised in the instant appeal.

The mental commitment statutes challenged in *J. L.* are typical of those generally in effect. Children under the age of 18 can be committed to institutions for the mentally ill against their will, at the request or with the consent of their parents or custodians. No child under 18 is afforded notice, an opportunity to consult with counsel or an evidentiary hearing, either prior to or following commitment. There are no requirements—as there are in Pennsylvania—that a child be interviewed by more than one psychiatrist, or that alternatives to hospitalization be considered by hospital staff.[21] There have been no changes in state law.

*J. L.* v. *Parham* was decided by a three-judge district court favorably to the claims of the plaintiffs and the class they represent on February 21, 1976. Appellants timely filed a notice of appeal and submitted a jurisdictional statement on May 21, 1976. Appellees' Motion for Plenary Review or in the Alternative to Affirm was filed on June 11, 1976. The case is thus ready for action by the Court and can be heard and decided in the October 1976 Term. For these reasons, the undoubted importance of the issues originally

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[20] Appellees in *J. L.* are among the amici here.

[21] GA. CODE ANN. § 88-503.



raised in the instant case does not militate in favor of reaching the merits of this appeal.

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Because of their concern that the important questions involved be decided in a context that permits their proper consideration, amici believe that a decision on the merits should not be made in the case *sub judice.* Nevertheless, in the discussion that follows, amici have set forth their arguments with respect to the necessity of evidentiary hearing rights in connection with the commitment of children, so that if the Court does reach the merits, these arguments can be considered.

## II.

## THE DUE PROCESS CLAUSE PROHIBITS THE COMMITMENT OF A CHILD TO A MENTAL INSTITUTION WITHOUT AN EVIDENTIARY HEARING, REGARDLESS OF THE CONSENT OF THE PARENT OR CUSTODIAN

### A. Due Process Requires Access to Counsel and an Evidentiary Hearing in Connection with Involuntary Civil Commitments

"There can be no doubt that involuntary commitment to a mental hospital . . . is a deprivation of liberty which the State cannot accomplish without due process of law." *O'Connor* v. *Donaldson,* 422 U.S. 563, 580 (1975) (Burger, C. J., concurring). A "[c]ommitment must be justified on the basis of a legitimate state interest, and the reasons for committing a particular individual must be established in an appropriate proceeding." *Id.*

Just last Term, this Court identified the factors that must be considered in determining the requirements of due process in a particular context:

> [I]dentification of the specific dictates of due process generally requires consideration of three

> distinct factors: first, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.

*Mathews* v. *Eldridge,* 424 U.S 319, ——, 96 S.Ct. 893, 903 (1976). *See also Wolff* v. *McDonnell,* 418 U.S. 539, 560 (1974); *Cafeteria and Restaurant Workers Union* v. *McElroy,* 367 U.S. 886, 895 (1961).

Consideration of these factors makes clear that due process requires that children committed to a mental institution be afforded access to counsel and the right to an evidentiary hearing to determine whether institutionalization is appropriate. First, enormous harm can result to a child from erroneous commitment. Second, there is a substantial risk of error in the present procedure for the commitment of juveniles, and this risk can be vastly reduced by a suitable hearing procedure where the basis for the commitment and the alternatives available can be dispassionately considered. And, third, the availability of hearings in the commitment situation is not unduly burdensome.

1. A Child Suffers Great Injury From An Erroneous Commitment

a. *Impact of Institutionalization*

A number of considerations underscore the substantial injuries and disabilities that result from an erroneous commitment.



First, commitment to a mental institution destroys the "continuity of relationships, surroundings and environmental influences [which] are essential for a child's normal development." J. Goldstein, A. Freud, and A. Solnit, Beyond the Best Interests of the Child 21 (1973).[22] Moreover, the committed child is placed in an environment characterized by constant staff turnovers, thus making it difficult, if not impossible, for him to develop new stable relationships. In *J. L.* v. *Parham, supra,* a psychiatrist described the impact of this dislocation on amicus J. L.:

> One of the things that I noticed about Joey is that he was—he latched onto whoever seemed to offer him what I would call a feeding experience, a nurturing experience, giving experience, at that moment. . . . [I]n an institutional setting because one doesn't have the mother and father to whom one can rely on for nurturance over an extended, really indefinite period of time, one has to make use of whoever is available at the moment. Also, one learns that the good guy or the good woman who might be available today might not be available on the next shift or . . . the next week or month, so one takes what one can when one can. I saw a great deal of that mentality in Joey.

*J. L.* v. *Parham, supra,* Deposition of Dr. Eli C. Messinger at 65. (Hereafter, "Mess. Dep.")

Second, placement in a mental institution necessarily interrupts a child's education, and frequently no alternative educational services are provided. At St. Elizabeths Hospital in Washington, D.C., for example, many

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[22] The authors further point out that disruption to the continuity of relationships is harmful for both young children and those of adolescent age. J. Goldstein, et al., supra, at 33-34.

children receive little or no education. *See Mills* v. *Board of Education* (D.D.C. No. 1939-71), Report to the Court of the D.C. Board of Education at 22-23 (April, 1975). No educational services at all are offered to children at Mississippi State Hospital. *D.L.K.* v. *Stubbs, supra,* Defendants' Answer to Interrogatory #10.[23]

Third, the committed child is denied the opportunity to explore and discover the world around him. Instead, he is placed in a "total institution"—"a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life." E. GOFFMAN, ASYLUMS xiii (1961). *Cf. In re Gault,* 387 U.S. 1 (1967).[24] Compliant and passive behavior is demanded of patients in the name of institutional efficiency. This situation is:

> diametrically opposed to the developmental needs of children. . . . Such role indoctrination is contrary to a juvenile's need to establish a sense of initiative within reasonable self-imposed limits and controls. . . . Although decisions about what to wear, when to eat or whom to visit may seem trivial, they are important arenas of self-expression. The lack of flexibility that characterizes mental hospital procedures does not foster the child's development of a sense of individuality or personal responsibility.



*Poe* v. *Mathews, supra,* Affidavit of Dr. Eli C. Messinger at 3-4. (Hereafter, "Mess. Aff."). Indeed, confinement in an institution frequently produces what is known as "institutional neurosis," a condition characterized by apathy, lack of initiative, loss of individuality and a deterioration in personal habits. R. BARTON, INSTITUTIONAL NEUROSIS (1959) as cited in D. VAIL, DEHUMANIZATION AND THE INSTITUTIONAL CAREER 140-144 (1966).[25]

Finally, the adverse effects of commitment do not end when the child is released from the institution. Both the record in this case and the professional literature demonstrate the scarring effect of being labelled "mentally ill." *See* A. 475, 574-75, 596, and 622.[26]

> [B]eing an ex-mental patient is more of a liability than being an ex-criminal in the pursuit of hous-

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[23] *See also Martin M.* v. *Shepherd, supra,* Testimony of Mr. Karl K. at 6 (Michael K. received "very little" schooling in the year in which he was confined at Connecticut Valley Hospital). (Hereafter, "Mr. Karl K., T. ——").

[24] The fact of the matter is that, however euphemistic the title, a "receiving home" or an "industrial school" for juveniles is an institution of confinement in which the child is incarcerated for a greater or lesser time. His world becomes "a building with whitewashed walls, regimented routine and institutional hours • • •." Instead of mother and father and sisters and brothers and friends and classmates, his world is peopled by guards, custodians, state employees, and "delinquents" confined with him for anything from waywardness to rape and homicide.

387 U.S. at 27.

[25] This situation is sometimes exacerbated by the use of psychotropic drugs, administered for the purpose of pacifying the child, rendering him more susceptible to management. *See infra,* p. 30.

[26] Last Term, in *Paul v. Davis,* 424 U.S. ——, 96 S.Ct. 1155 (1976), this Court again recognized that "stigma" resulting from government action is "an important factor in evaluating the extent of harm worked by that act, . . ." 96 S.Ct. at 1164. *See also Wisconsin* v. *Constantineau,* 400 U.S. 433 (1971).

> ing, jobs, and friends. Mental patients have for years been regarded with more distaste and less sympathy than virtually any other disabled group in our society. . . .

Rabkin, *Public attitudes toward mental illness: a review of the literature,* SCHIZOPHRENIA BULLETIN at 10 (Issue #10, Fall 1974).[27]

What is worse, a formerly committed individual tends to perceive society's negative response to him as a valid measure of his personal worth. The label becomes a "double-edged blade," causing "him to demean himself and to magnify social ostracism." *In re Ballay,* 482 F.2d 648, 669 (D.C. Cir. 1973). *See also* Cumming and Cumming, *On the Stigma of Mental Illness,* 1 COMMUNITY MENTAL HEALTH JOURNAL 135, 136 (1965).

The problems of stigma are increased for children because children are more impressionable than adults and are even more likely to accept as true society's judgment that they are "crazy." A child also faces a

[27] In a study reported in Tringo, *The hierarchy of preference toward disability groups,* 4 JOURNAL OF SPECIAL EDUCATION 295 (1970), it was found that of 21 disability groups including ex-convicts and alcoholics, the mentally ill ranked lowest in public esteem. *See also* J. NUNNALLY, POPULAR CONCEPTIONS OF MENTAL HEALTH: THEIR DEVELOPMENT AND CHANGE 42-51 (1961). It is important to note that the general public associates mental illness with the fact of hospitalization, but does not attach this label to less drastic forms of psychiatric or psychological therapy. *See* Goffman, *Career of the Mental Patient,* 22 PSYCHIATRY: JOURNAL FOR THE STUDY OF INTERPERSONAL PROCESSES 123 (May 1959); Johannsen, *Attitudes toward mental patients: a review of empirical research,* 53 MENTAL HYGIENE 218 (1969); Phillips, *Public identification and acceptance of the mentally ill,* 56 AMERICAN JOURNAL OF PUBLIC HEALTH 755 (1966).



peer group less tolerant of different experiences and is more likely to find himself socially outcast. Returning to school presents special problems for children:

> [F]ew students are mature enough to be entirely at ease with the child newly returned from a mental hospital. The failure of hospitals to provide educational programs for many juvenile mental patients means that there is a significant learning gap to overcome in addition to the social problems. Behind in their schoolwork, embarassed by peer group questioning, and under the watchful eye of school administrators, juveniles have a particularly difficult time reintegrating themselves into the school routine.

*Poe* v. *Mathews, supra,* Mess. Aff. at 6. *Cf.* N. HOBBS, FUTURES OF CHILDREN: CATEGORIES, LABELS, AND THEIR CONSEQUENCES 131 (1974).

In the case of a child who is actually in need of commitment to a mental institution, these detrimental effects are the unfortunate price that must be paid to enable the child to overcome mental illness that cannot be treated by less drastic means. But where a child is committed unnecessarily, he obviously pays a very heavy price for the error.

b. *The Harmful Conditions at Many Institutions*

The preceeding discussion addresses the consequences to a child of commitment, apart from the question of quality of the available facilities. But the conditions in many of these institutions are not fit for the confinement of children.

The Joint Commission on the Mental Health of Children [28] has reported that "most" mental institutions for children are "disgraceful and intolerable."

> Each year, increasing numbers of [children] are expelled from the community and confined in large state hospitals so understaffed that they have few, if any, professionals trained in child psychiatry and related disciplines.
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> * * *
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> In most of these hospitals the usual practice is to place youngsters in wards with adult patients, frequently with those who are in an advanced stage of mental deterioration. These children and youth receive little, if any, therapeutic care, and no provision is made for the continuation of their education. An imprecisely determined number are left to "rot on the back wards," condemned to a hopeless life of continuing institutionalization.

CRISES IN CHILD MENTAL HEALTH: CHALLENGE FOR THE 1970's: REPORT OF THE JOINT COMMISSION ON THE MENTAL HEALTH OF CHILDREN 5, 269 (1969).[29]

Unfortunately, the institutions to which amici have been committed conform to this description. The Joint Commission on Accreditation of Hospitals

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[28] The Joint Commission on the Mental Health of Children was established by the U.S. Department of Health, Education and Welfare pursuant to amendments to the Social Security Act, July 30, 1965, Pub. L. 89-97, § 231(a)-(d), 79 Stat. 360. It was composed of "representatives of leading national medical, welfare, educational, and other professional associations, organizations, and agencies active in the field of mental health of children." *Id.* § 231(c).

[29] *See also* Cohen, Granger, Provence, and Solnit, *Mental Health Services*, in ISSUES IN THE CLASSIFICATION OF CHILDREN, Vol. II, 106-07 (N. Hobbs ed. 1975).



("JCAH")[30] has found that St. Elizabeths Hospital lacks sufficient numbers of qualified professional staff. JCAH RECOMMENDATIONS AND COMMENTS ON ST. ELIZABETHS HOSPITAL 3 (Sept., 1975). (Hereafter, "JCAH ST. ELIZ. REC."). At Mississippi State Hospital, where amicus D.L.K. was confined, many nursing positions remain unfilled. As a result, between midnight and eight in the morning only one registered nurse is on duty for approximately 3,500 patients. MISSISSIPPI LEGISLATIVE AUDIT COMMITTEE, REPORT TO THE MISSISSIPPI LEGISLATURE: A PERFORMANCE EVALUATION OF THE MISSISSIPPI STATE HOSPITAL AT WHITFIELD 16 (Sept., 1975) (Hereafter, "MISS. EVAL. RPT."). Inadequate staffing has also been identified as a serious problem in state mental institutions in Georgia. REPORT OF THE GEORGIA STUDY COMMISSION ON MENTAL HEALTH SERVICES FOR CHILDREN AND YOUTH 81-86, C-2 (1973). (Hereafter, "GA. COMM. RPT.").

Despite the lack of staff to supervise and protect them, children in these institutions are frequently confined with adults. In Georgia:

> [in] many cases, youth are housed on geographic units with disturbed adults. Staff were concerned that in these units adolescents are continuously confronted with pathological adult behavior patterns at a time in their psychological development when healthy role models are needed to help them develop an individual sense of identity.

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[30] The Joint Commission on Accreditation of Hospitals is a private body which inspects a wide range of medical treatment facilities and certifies them according to professionally accepted standards. *JCAH, Accreditation Manual for Psychiatric Facilities Serving Children and Adolescents* iii (1974).

GA. COMM. RPT. at C-1. *See also J.L.* v. *Parham, supra,* Deposition of Dr. Lawson H. Bowling at 25 (hereafter, "Bowling Dep."); Mess. Dep. at 33-35. And in Mississippi, juveniles are placed on wards with "adults, persons charged with crimes, alcoholic patients, narcotic patients, sex offender patients and aggressive homosexual patients." *D.L.K.* v. *Stubbs, supra,* Defendants' Answers to Interrogatories #12-13.[31]

The physical facilities at these institutions are also severely deficient and even dangerous. The Mississippi State Hospital, where amicus D.L.K. was confined

> has been unable to maintain its buildings. . . . The plaster on the walls of many of the buildings is peeling and crumbling. Employees and patients accept the leaking ceilings and faulty plumbing as a way of life. The presence of rats, roaches, and flies are a serious sanitation problem.

MISS. EVAL. RPT. at 13-14. The JCAH found that this facility had undesirable odors, broken windows, unrepaired screens and wallboards and was a fire hazard. JCAH RECOMMENDATIONS AND COMMENTS ON MISSISSIPPI STATE HOSPITAL AT WHITFIELD 2, 5-6 (April, 1975) (Hereafter, "JCAH MISS. REC."). At St. Elizabeths in Washington, D.C., the JCAH found that some buildings did not even show evidence of routine clean-

[31] Amicus Michael K. was confined on both locked and open wards with adults for nearly the entire duration of his year-long confinement at Connecticut Valley Hospital. *Martin M.* v. *Shepherd, supra,* Mr. Karl K., T. at 5-7. Similarly, children and adults are mixed on many of the wards at St. Elizabeths Hospital. *See Poe* v. *Mathews, supra,* Defendants' Answer to Plaintiffs' First Interrogatory #27. Overall, fifty percent of all juveniles admitted to state, county and private mental institutions in 1971 were placed on adult wards. *See National Institute of Mental Health,* HOSPITAL INPATIENT TREATMENT UNITS FOR EMOTIONALLY DISTURBED CHILDREN, UNITED STATES, 1971-72 1 (1972).



ing and maintenance. JCAH ST. ELIZ. REC. at 7. The Georgia institutions not only have inadequate bed space but lack sufficient space to conduct appropriate therapy programs. GA. COMM. RPT. at C-1.

Given these facts, it comes as no surprise that several of the institutions in which amici have been confined have been denied accreditation.[32] Dr. W. L. Jaquith, former director of Mississippi State Hospital, testified:

> I couldn't meet . . . these standards that have been submitted. There is no way . . . to meet them. The hospital was built in 1925, opened in 1935. . . . One of the things that I would have to be perfectly honest with the Court is . . . in the long-term cottages and buildings, there is little privacy. *It is dehumanizing.*

*McCraw* v. *Jaquith,* Civil No. 92, 361 (Chancery Court of the First Judicial District, Hinds County, Miss.), Testimony at 63 (April 18, 1974). (Emphasis added). Accreditation also has been denied to St. Elizabeths Hospital in Washington, D.C. (*see* letter of November 24, 1975 from JCAH to Dr. Roger Peele, Acting Superintendent, St. Elizabeths Hospital) and to several of the mental institutions in Georgia in which juveniles are confined. *See J.L.* v. *Parham, supra,* Deposition of Dr. Douglas Skelton at 11-12.[33]

[32] Such accreditation by the JCAH is required for an institution to receive reimbursement from the federal medicaid program for in-patient psychiatric services provided to children. 42 U.S.C. § 1396d(h)(1)(A).

[33] JCAH also offers a separate accreditation to mental hospitals which specifically qualify to treat juveniles and adolescents. Only 21 state and county mental hospitals in the entire country are so accredited. Letter dated May 26, 1976 from JCAH to Linda Lipton, counsel for amici.

Apart from the inadequate staffing and deficient physical facilities, it has recently been reported that at state mental institutions psychotropic medication is frequently administered to patients to sedate them for the convenience of the institutional staff, without the supervision of physicians and in hazardous circumstances. *See* Testimony of A. Brandt and J. W. Ellis, Hearings on Institutional Drug Abuse Before the Subcommittee on Juvenile Delinquency of the Senate Committee on the Judiciary, 94th Cong., 1st Sess. (1975). The long term use of such medication on children can have particularly harmful side effects such as retardation of a child's growth, increase in heart rate, involuntary body movements, elevation of blood pressure and acute toxic psychotic reactions. *J. L.* v. *Parham, supra,* Mess. Dep. at 32.

The poor quality of mental facilities available for children in this country only serves to underscore the enormous harm to a child that results from an erroneous decision to commit.

2. THERE IS A SUBSTANTIAL RISK OF ERROR IN PSYCHIATRIC RECOMMENDATIONS OF COMMITMENT, AND THIS RISK CAN BE REDUCED BY APPROPRIATE PROCEDURAL SAFEGUARDS

a. *The Risk of Error*

Despite the enormous harm to the child that results from an erroneous decision to commit, due process might not require a hearing if the likelihood of error was relatively slight. In fact, however, there is a very substantial risk of error in psychiatric recommendations of confinement.



i. *Institutional Psychiatrists are Predisposed to Recommend Confinement*

The tendency of psychiatrists connected to mental institutions to prescribe institutionalization for persons not in need of confinement has been widely noted and has been confirmed by empirical study.[34] The Georgia Study Commission on Mental Health Services for Children and Youth, for example, found that more than half of the institutionalized children in Georgia did not need to be so confined. *J.L.* v. *Parham, supra,* 412 F. Supp. at 122. And a recent report by the National Institute of Mental Health noted that only 26 percent of the patients below the age of 20 confined at St. Elizabeths Hospital were in need of institutionalization. NATIONAL INSTITUTE OF MENTAL HEALTH, STATISTICAL NOTE 115, CHILDREN AND STATE MENTAL HOSPITALS at 4 (1975).

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[34] *See, e.g.,* T. SCHEFF, BEING MENTALLY ILL: A SOCIOLOGICAL THEORY 105-21 (1966); Bazelon, *Institutionalization, Deinstitutionalization and the Adversary Process,* 75 Colum. L. Rev. 897, 900 (1975); Dershowitz, *Psychiatry in the Legal Process: A Knife That Cuts Both Ways,* 4 TRIAL 29, 32-33 (Feb./March 1968); Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions,* 62 CALIF. L. REV. 840, 863-68 (1974); Ennis and Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom,* 62 CALIF. L. REV. 693, 711-19 (1974); Livermore, Malmquist, and Meehl, *On the Justifications for Civil Commitment,* 117, U. PA. L. REV. 75, 83-84 (1968); Rosen, *Detection of Suicidal Patients: An Example of Some Limitations in the Prediction of Infrequent Events,* 18 J. OF CON. PSYCHOLOGY 397 (1954); *Note, The Role of Counsel in the Civil Commitment Process: A Theoretical Framework,* 84 YALE L. J. 1540, 1553-54 (1975); *People* v. *Burnick,* 14 Cal. 3d 306, 535 P. 2d 352, 121 Cal. Rptr. 488 (1975); *In re Long,* 25 N.C. App. 702, 214 S.E. 2d 626, 629, *cert. denied,* 288 N.C. 241, 217 S.E. 2d 665 (1975); *J.L.* v. *Parham, supra,* Deposition of Dr. Walter R. Gove at 95.

Rappeport, Lassen and Gruenwald studied the progress of 38 persons who obtained release from a state mental institution over the objection of the institution's psychiatrists.[35] After a year or more, nearly half of the 38 had made a satisfactory adjustment to the community, *i.e.*, they had not been in serious trouble with the law, had not been rehospitalized, and were caring for themselves. Of equal significance, no serious anti-social behavior occurred among any of the 38, although a number of patients who did not adjust were involved in minor accidents or criminal infractions.[36]

A number of factors explain the tendency of psychiatrists to recommend institutionalization where it is not needed. First, the ethics of the medical profession dictate erring on the side of caution.[37] Because the consequences of not treating an individual for a suspected

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[35] Rappeport, Lassen and Gruenwald, *Evaluation and Follow-up of State Hospital Patients Who Had Sanity Hearings,* 118 Am. J. Psychiat. 1078 (1962). Twenty-six of the thirty-eight were released after a judicial hearing. The remaining twelve escaped.

[36] These findings are further supported by a study conducted as follow-up to this Court's decision in *Baxstrom* v. *Herold,* 383 U.S. 107 (1968). Each of 969 patients who had been detained in maximum security hospitals by the New York Department of Corrections because psychiatrists had determined them to be mentally ill and too dangerous for release or even for transfer to civil hospitals were transferred to civil hospitals. Within a year after their transfer, 147 had been discharged to the community and only 7 had to be recommitted to a prison hospital. Hunt and Wiley, *Operation Baxstrom After One Year,* 124 Am. J. Psychiat. 974 (1968). *See also* Steadman and Keveles, *Community Adjustment and Criminal Activity of the Baxstrom Patients: 1966-70,* 129 Am. J. Psychiat. 304 (1972) and studies cited in Ennis and Litwack, *supra,* 62 Calif. L. Rev. at 711-16.

[37] *See* T. Scheff, supra, at 105-21; Ellis, *supra,* at 865-66; Rosenhan, *On Being Sane in Insane Places,* 13 Santa Clara Law. 379, 385 (1973).



physical illness are likely to be more serious than the consequences of unnecessary treatment or further diagnosis, such caution, in the case of physical illness, may work to the benefit of the patient. But in the case of mental illness, where "caution" can result in unnecessary commitment to a mental institution, this is clearly not the case.

Second, psychiatrists tend to think in terms of psychopathology. Shah, *Crime and mental illness: some problems in defining and labeling deviant behavior,* 53 Mental Hygiene 21, 26 (1969); *J.L.* v. *Parham, supra,* Mess. Dep. at 16-17. They are apt to diagnose mental illness from ambiguous behavior rather than recognizing equally plausible, yet non-pathological explanations for the behavior. Kumasaka and Gupta, *Lawyers and Psychiatrists in the Court: Issues on Civil Commitment,* 32 Md. L. Rev. 6, 34 (1972). An example of this was recorded in a study conducted by Dr. Rosenhan, *On Being Sane In Insane Places,* 13 Santa Clara Law. 379 (1973). In the study, eight normal persons presented themselves for voluntary admission at twelve different mental institutions. The only symptom the subjects pretended to exhibit was hearing voices. Beyond this, they acted normally and were truthful in describing themselves and their history. In every instance, the subject was admitted to the hospital with a diagnosis of schizophrenic or manic-depressive psychosis.

Rosenhan described one of his subjects as having

> had a close relationship with his mother but was rather remote from his father during early childhood. During adolescence and beyond, however, his father became a close friend, while his relationship with his mother cooled. His present relation-

> ship with his wife was characteristically close and warm. Apart from occasional angry exchanges, friction was minimal. The children had rarely been spanked.

*Id.*, at 387. But on the basis of the same information, the case summary prepared by the institution portrayed a mentally ill individual:

> This white 39 year-old male . . . manifests a long history of considerable ambivalence in close relationships, which begins in early childhood. A warm relationship with his mother cools during his adolescence. A distant relationship to his father is described as becoming very intense. Affective stability is absent. His attempts to control emotionality with his wife and children are punctuated by angry outbursts and, in the case of children, spankings. And while he says that he has several good friends, one senses considerable ambivalence embedded in those relationships also . . . .

Third, reinforcing the tendency of psychiatrists to commit persons who do not need to be institutionalized is the fact that erroneous denials of institutionalization are far more likely to come to their attention than erroneous admissions. When a psychiatrist mistakenly concludes that someone is not in need of institutionalization, that person will likely be brought back to the institution, and the psychiatrist will learn of his mistake. When someone is mistakenly committed, however, subsequent "normal" behavior will be attributed to the positive effects of institutionalization rather than to a mistaken commitment. For these reasons, psychiatrists become aware of their mistakes only when they deny commitment, and this further inclines them to a decision to commit in future doubtful cases. *See* Dershowitz, *supra,* at 32-33; *Note, The Role of Counsel in the Civil Commitment Process, supra,* at 1554.



Fourth, by erring on the side of institutionalization rather than outpatient care, the psychiatrist avoids the possibility that he or the institution will be held responsible, or even liable, if the child should cause harm to himself or others after institutionalization has been denied. *Cf. Hicks* v. *United States,* 511 F. 2d 407 (D.C. Cir. 1975); *Underwood* v. *United States,* 356 F. 2d 92 (5th Cir. 1966); *Fair* v. *United States,* 234 F. 2d 288 (5th Cir. 1956). There is no comparable risk in the case of mistaken commitments. *See* Dershowitz, *supra,* at 32-33; Bazelon, *supra,* at 400; *Note, The Role of Counsel in the Civil Commitment Process, supra,* at 1554; *Poe* v. *Mathews, supra,* Mess. Aff. at 11.

Finally, institutional psychiatrists have knowledge of and confidence in the benefits of institutionalization. On the other hand, they frequently lack knowledge in the use and availability of community-based facilities or other possible outpatient alternatives. This familiarity with one alternative and lack of familiarity with the other increases the likelihood of a recommendation of commitment. *See* A. 608-09; *J.L.* v. *Parham, supra,* Mess. Dep. at 16-17.

ii. *Psychiatric Judgments are Inherently Unreliable*

The Chief Justice has pointed out that "there can be little responsible debate regarding 'the uncertainty of diagnosis in this field and the tentativeness of professional judgment.'" *O'Connor* v. *Donaldson,* 422 U.S. 563, 584 (1975) (concurring opinion).

> Psychiatrists themselves would be the first to admit that however desirable an infallible crystal ball might be, it is not among the tools of their profession. It must be conceded that psychiatrists

still experience considerable difficulty in confidently and accurately diagnosing mental illness.

*People* v. *Burnick, supra,* 14 Cal. 3d at 326-27, 535 P. 2d at 365, 121 Cal. Rptr. at 501 (1975). *See also In re Ballay, supra,* 482 F. 2d at 665 (D.C. Cir. 1965); Ennis and Litwack, *supra,* at 719.

Experience with the insanity defense in the criminal law is a vivid reminder of the frequency with which psychiatrists disagree as to a diagnosis. In such cases, conflicting psychiatric evidence is the rule, not the exception:

> [M]edical witnesses time after time express directly opposite opinions in the witness box concerning the sanity of prisoners on trial. . . .

*Blocker* v. *United States,* 288 F. 2d 853, 869 n. 28 (D.C. 1961) (Burger, J., concurring).[38]

The point, simply, is that diagnosis of mental illness is an area of inherent uncertainty and consequent high risk of error.

iii. *Decisions to Confine Children to Mental Institutions Are Generally Made Without Adequate Information or Adequate Exposure to the Child*

In the context of evaluating children whose commitment to a mental institution is proposed, the likelihood of error is exacerbated by the limited information on which the commitment decision is generally based.

[38] An example of the inability of psychiatrists to agree on the diagnosis of a child is found in the record in *J.L.* v. *Parham, supra.* One of the amici there received the conflicting diagnoses of adjustment reaction of childhood and hyperkinetic disorder. *See* Mess. Dep. at 18.



A psychiatrist should have as much knowledge as possible of a child's situation in order to decide whether to institutionalize the child. S. CHESS, AN INTRODUCTION TO CHILD PSYCHIATRY 47 (2nd ed. 1969). Well established psychiatric procedure calls for several interviews with a child over a period of time. "It is rarely possible to do a complete mental status evaluation in less than two or three interviews." J. SIMMONS, PSYCHIATRIC EXAMINATION OF CHILDREN 6 (2nd ed. 1974); GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, *The Diagnostic Process in Child Psychiatry* 313 in 3 REPORTS AND SYMPOSIUMS, REPORT No. 38 (1957); T. SCHEFF, *supra,* at 174."[39]

The reason for this is that a child is likely to experience deep anxiety at the first clinical interview and is therefore unlikely to place in the psychiatrist the trust and confidence requisite for a successful psychiatric evaluation. A. 478-79; J. SIMMONS, *supra,* at 1; GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, REPORT No. 38, *supra,* at 338-42. In addition, children often experience great fluctuations in behavior over short periods of time, particularly in different settings. "Adolescence is normally a time of emotional turmoil, behavioral excesses and rapid change. One can expect alterations and fluctuations in behavior. . . ." *Poe* v. *Mathews, supra,* Mess. Aff. at 11. *See also* Ennis and Litwack, *supra,* at 723-24; T. SCHEFF, *supra,* at 174; A. 595.

In fact, however, psychiatric judgments on children whose commitment is sought are typically based on

[39] The Menninger Foundation recommends that evaluations be done by a team of specialists rather than by a lone psychiatrist. THE MENNINGER FOUNDATION CHILDREN'S DIVISION, DISTURBED CHILDREN: EXAMINATION AND ASSESSMENT THROUGH TEAM PROCESS (1969).

short interviews with the child. For example, in the instant case, the psychiatrist in charge of the unit at Haverford State Hospital in which the plaintiffs were held testified that admission evaluations last only 45 minutes to an hour, "or shorter." A. 47. And at St. Elizabeths Hospital in Washington, the overwhelming majority of children are committed on the same day in which application is made. *Poe* v. *Mathews, supra,* documents filed in response to Plaintiffs' First Interrogatories #26.

Compounding the problem of inadequate exposure to the child is the often unreliable information upon which admitting psychiatrists base their diagnoses of children. The applicant for admission, whether parent or state agency, is likely to be the psychiatrist's primary, and possibly sole, source of information.[40] The limitations of a state agency in this regard are obvious. But even when the parents are the applicants, the information conveyed is likely to be replete with distortions and inaccuracies. The parents themselves may be suffering from behavioral problems, or may be experiencing such anxiety and nervousness as to undermine the accuracy of their observations. A. 478. In the midst of the crisis situation which triggered the application for commitment, the parents "are more likely to focus on the behavioral characteristics of the child that

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[40] That psychiatrists often fail to obtain information from sources other than the petitioning state agency or parent was admitted by Dr. John Gates, Superintendent, Central State Hospital:

> Now the fact of the matter is, of course, that you don't always get information about the child from other sources, and the fact of the matter is that sometimes the people don't make the contacts they should make.

*J.L.* v. *Parham, supra,* Deposition at 6. *Cf.* A. 637-38.



they find unpalatable or which they consider sick and deviant." *J.L.* v. *Parham, supra,* Mess. Dep. at 10. Thus, they may omit crucial pieces of information or otherwise present biased information. S. CHESS, *supra,* at 73; A. 592.[41]

Experts in child psychiatry stress that information should be obtained from a wide variety of sources. Both joint and separate interviews should be conducted with the parents. J. SIMMONS, *supra,* at 116-17, 122; S. CHESS, *supra,* at 50-54. Yet state statutes generally do not even require that both parents participate in the commitment decision or that the psychiatrist consult with both parents. And, in fact, the psychiatrist often sees only one parent prior to institutionalizing a child. Four of the plaintiffs in the instant case, for example, were committed on application of only one parent. A. 788-89.

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[41] Even when the examining psychiatrists form different conclusions about the behavior of the child than does the parent, they are often inclined to identify with the parent and seek to satisfy him rather than the child.

> While the goal of the psychiatrist will be expressed—and perceived—as the best welfare of the child-patient, it is the parent who has come to seek help, whose situation seems most desperate, . . . who is closest to the psychiatrist in age and social outlook. . . .

Ellis, *supra,* at 868. (Citations omitted). *See also In re Long, supra.* An example of this was noted by Dr. Messinger in his testimony about one of the amici in *J.L.* v. *Parham, supra.* Joey's adoptive mother and her second husband described him as hyperactive and rebellious against and unwilling to listen to authority. His conduct in the psychiatric interview belied such an observation; Joey was cooperative and without hyperactivity. Faced with such a discrepancy, however, the psychiatrist chose to institutionalize him. Mess. Dep. at 12-13.

b. *The Right to Counsel and an Evidentiary Hearing Would Substantially Reduce the Risk of Error*

The procedures required by the due process clause depend on "the need for and usefulness of the particular safeguard in the given circumstances. . . ." Friendly, *Some Kind of Hearing,* 123 U. Pa. L. Rev. 1267, 1278 (1975). In cases of the commitment of children to mental institutions, there is an indispensible need for counsel and for a full evidentiary hearing.

In recognition of this, most state statutes grant these safeguards to adults in connection with involuntary commitment proceedings. *See, e.g.,* 50 Pa. Stat. Ann. § 4406; D.C. Code § 21-541; Cal. Welf. and Inst'ns Code § 5300-05; Mo. Stat. Ann. § 202.807; Rev. Code Wash. Ann. § 71.05. 310. And state and federal courts have uniformly held that these safeguards are constitutionally required.[42] The necessity of access to counsel and the right to a full evidentiary hearing to assure fundamental fairness is no less in the case of proceedings to commit children.

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[42] *See, e.g., Barry* v. *Hall,* 98 F. 2d 222, 225-26 (D.C. Cir. 1938); *Suzuki* v. *Quisenberry,* —— F.Supp. ——, Civ. No. 73-3854 (D. Haw. Feb. 24, 1976); *Doremus* v. *Farrell,* 407 F.Supp. 509 (D. Neb. 1975); *Kendall* v. *True,* 391 F. Supp. 413, 419 (W.D. Ky. 1975) (three-judge court); *Bell* v. *Wayne County General Hospital,* 384 F. Supp. 1085, 1091 (E.D. Mich. 1974) (three-judge court); *Lynch* v. *Baxley,* 386 F. Supp. 378, 388 (M.D. Ala. 1974) (three-judge court); *Lessard* v. *Schmidt,* 349 F. Supp. 1078, 1090 (E.D. Wis. 1972) (three-judge court), *remanded,* 414 U.S. 473 (1974) *on remand,* 379 F. Supp. 1376 (1974), *remanded,* 421 U.S. 957 (1975); *Dixon* v. *Attorney General of the Commonwealth of Pennsylvania,* 325 F. Supp. 966, 974 (M.D. Pa. 1971) (three-judge court); *State ex rel. Fuller* v. *Mullinax,* 364 Mo. 858, 269 S.W. 2d 72 (1954); *State ex rel. Hawks* v. *Lazaro,* 202 S.E. 2d 109 (W. Va. 1974); *cf. Specht* v. *Patterson,* 386 U.S. 605, 608 (1967); *Minnesota ex rel. Pearson v. Probate Court,* 309 U.S. 270 (1940).



The value of counsel in this setting begins with the initial interview with the child.

> If prospective juvenile patients were able to see someone they knew was their advocate, in a setting outside the hospital examining room, they might present a lot more information and a lot different sounding information than in the interview with the psychiatrist in a hospital admitting office.

*Poe* v. *Mathews, supra,* Mess. Aff. at 13. In this interview the lawyer and the child can explore the question whether to contest the proposed commitment or acquiesce in it. The court below rightly concluded that a child may not waive his hearing rights until counsel is appointed and has consulted with the child. A. 811 n. 26.

This is particularly necessary when the hearing follows confinement as it does under the district court order. In that situation, the child is cut off from his friends and all outside contacts. He is told both by his parents and the staff of the institution that commitment is in his best interest. A. 284-85. Lacking "someone concerned with securing him [his] rights [with] . . . more mature judgment as to the steps he should take" (*Gallegos* v. *Colorado,* 370 U.S. 49, 54 (1962)), the child is likely to acquiesce in the commitment and waive his right to a hearing.[43] Such a waiver will more likely be the product of "fantasy, fright or despair"

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[43] A child is also subject to pressures toward waiver when the hearing precedes the commitment. The child's parents or social worker will be telling him that it is best to forego a hearing, as will the institutional psychiatrist. Once again, the child will have no one to whom he can turn to openly discuss his feelings. Without the benefit of independent consultation and advice, the child's decision is likely to be a reflection of the will of those seeking his commitment rather than a free and voluntary choice.

(*In re Gault, supra,* 387 U.S. at 55) than an "intentional relinquishment or abandonment" of a fully known right. *Johnson* v. *Zerbst,* 304 U.S. 458, 464 (1938).

If the hearing is not waived, the involvement of counsel will vastly improve the range and quality of the data that are brought to bear on the decision whether to commit a child. In addition to the likelihood that counsel will secure better information from the child, counsel will be in a position to obtain other relevant data that may not be volunteered by the parents, such as information relating to abuse of the child by the parents or prior attempts to secure commitment. *Poe* v. *Mathews, supra,* Mess. Aff. at 13. In addition, counsel can secure and present the opinions of a psychiatrist not associated with the institution as to the need for confinement and the possibilities of less restrictive forms of treatment that may be appropriate. This is particularly important because of the general unreliability of the recommendations to commit made by institutional psychiatrists.

The child's attorney would also have the opportunity independently to investigate alternative treatment facilities.[44] In this effort, social workers from state mental health departments or those connected to ju-

[44] In New York City for example, where counsel-advocates work within the admitting hospitals, one of their principal functions has been to seek alternatives to hospitalization satisfactory to their clients (and to the hospital as well) so that long-term hospitalization together with the disabilities and dependencies it involves can be avoided.

Andalman and Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey, A Polemic and A Proposal,* 45 Miss. L. J. 43, 47 (1974).



venile courts could be of assistance to counsel.[45] In some cases, counsel will locate alternatives to institutionalization to which the parents would agree, and services could be arranged in lieu of going forward with the commitment hearing.

An evidentiary hearing, with representation of the child by counsel, would provide an opportunity to delve into the accuracy of the facts upon which the psychiatric judgment is based, to the extent they are in dispute. As in other proceedings where a child's actions are at issue,[46] an evidentiary hearing before an impartial officer with due notice[47] and the opportunity to present and cross-examine witnesses,[48] will "en-

[45] *See, e.g.,* GA. CODE ANN. § 24A-601 to -02 which provides for a probation officer to assist juvenile courts in finding alternative placements for children under their jurisdiction, and Mich. Stat. Ann. § 14.800 (469) (2), requiring reports to be filed with the court in the course of civil commitment hearings by agencies or individuals knowledgeable about alternative treatment programs in the person's home community.

[46] Many of the facts that may be at issue in a commitment case are similar to those at issue in a delinquency proceeding. The court below found that the commitment of juveniles to mental institutions had been triggered by such alleged actions as "running away, robbing a gas station, stealing in general, chasing and striking a girl, arson, delinquent behavior in general, truancy. . . ." A. 790.

[47] Without adequate notice the right to a hearing is of little significance. *Mullane* v. *Central Hanover Trust Co.,* 339 U.S. 306, 314 (1950). Notice should include a statement of the factual and diagnostic bases for the proposed commitment, so that an adequate response can be prepared. *Cf. In re Gault, supra,* 387 U.S. at 33.

[48] In *Specht* v. *Patterson, supra,* 386 U.S. at 610, the Court held that persons have the right to present evidence and confront witnesses in commitment hearings held under the Colorado Sex Offenders Act. These rights are no less important here. While the right to appear personally is also essential if the juvenile is to have a fair opportunity to explain his behavior, the court below was

hance the possibility that truth will emerge from the confrontation of opposing versions and conflicting data." *In re Gault, supra,* 387 U.S. at 21.[49] An evidentiary hearing would also promote discussion and review of available programs offering alternative treatment services to those found at the mental institution in question.[50]

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cognizant of the fact "that situations exist where the absence of such persons from commitment proceedings may serve their own best interest." A. 805-06. Thus, it held that the right to appear personally may be waived, either by the juvenile or by the child's counsel, and that such a waiver shall be accepted by the impartial tribunal "upon a finding that the child is too ill to attend the proceedings." A. 806.

[49] The value of counsel is demonstrated by a study by Wenger and Fletcher. They monitored nearly 100 commitment hearings in one court and found that in 91 percent of the cases in which only the psychiatrist, respondent and referee were present, the psychiatrist recommended commitment. But in only 26 percent of the cases in which counsel represented the respondent was commitment recommended. Significantly, of respondents *without* counsel, 10 of 15 whom the authors judged not to be in need of commitment and all 25 who were thought to be borderline cases, were committed. Wenger and Fletcher, *The Effect of Legal Counsel on Admissions to a State Mental Hospital: A Confrontation of Professions,* 10 J. OF HEALTH AND SOC. BEH. 66, 68-71 (1969). *See also* Gupta, *New York Mental Health Information Service: An Experiment In Due Process,* 25 RUTGERS L. REV. 405, 437-38 (1974).

[50] Examination of alternatives is already required under some civil involuntary commitment schemes. *See, e.g.,* Rule 3, Mental Health Rules of the Superior Court of the District of Columbia, requiring that the D.C. Mental Health Commission file a report on each individual recommended for commitment setting forth "what less restrictive alternatives to hospitalization the Commission has considered, and why these alternatives will or will not be appropriate"; Mich. Stat. Ann. § 14.800 (469) (1) ("Prior to ordering any course of treatment, the court shall determine whether there exists an available program of treatment for the individual which is an alternative to hospitalization. The court shall not order hospitalization without a thorough consideration of available alternatives."); *see also* KAN STAT. ANN. § 59-2917 (effective July 1, 1976); OHIO REV. CODE § 5122.15(E) (effective August 1, 1976); and Rev. Code Wash. Ann. §§ 71.05.290(2) and 71.05.320(1). *Cf. J.L.* v *Parham, supra,* 412 F. Supp. at 124-25, 139, noting that 46 children in Georgia mental institutions could be cared for in less drastic, non-institutional environments such as small group crisis homes, specialized foster parent programs, or in their own communities with special home care services, and requiring the state to place these children in such appropriate facilities.



In short, counsel and an evidentiary hearing are the precise safeguards that will be effective in reducing the risk of error in the commitment of children to mental institutions. This procedure will necessarily expand the base of information on which a final decision is made, and provide the opportunity to consider conflicting professional diagnoses and alternative recommendations for treatment, where appropriate. And if a hearing is not held, participation of counsel will insure that a waiver is consistent with the best interests of the child.[51]

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[51] If an evidentiary hearing is to be held in non-emergency cases, it should precede the commitment, just as it does in cases of adults. In non-emergency situations, no harm can result from the brief delay caused by a pre-commitment hearing. But children who are found at a hearing not to be in need of commitment will be spared the deprivation of liberty and the harm they would have suffered as a result of mistaken institutionalization pending a post-commitment hearing. A child's sense of time is such that even a few days in a mental institution can seem a lifetime:

> Children and adolescents have a different sense of time than adults. Events of short duration can be experienced by juveniles as lengthy. The consequences of hospitalization—loss of schooling, exposure to frightening and disturbed behavior—will all take a serious toll on a youngster, regardless of the length of time spent inside the hospital walls.

*Poe* v. *Mathews, supra,* Mess. Aff. at 7. If the child in the non-emergency case is permitted to remain at home pending the hearing, the need for institutionalization may be altogether obviated:

> Since youngsters are quite fluid and change very quickly, a

### 3. A Child's Entitlement to an Evidentiary Hearing Would Not Impose a Substantial Burden on the State

There are over half a million admissions for inpatient treatment of psychiatric disorders made annually,[52] and evidentiary hearings are routinely accorded to adults who resist commitment and to children whose parents do not consent to commitment. The states have not found the right to an evidentiary hearing a great fiscal or administrative burden. Extending that right to all children would result in little additional cost.

In Georgia, for example, only 154 children were confined in institutions pursuant to voluntary procedures on January 31, 1976.[53] Nationally, only 9 percent of

delay will often allow a crisis to pass and thus avoid unnecessary hospitalization.

*Id.*, at 14; A. 594-95.

Further, studies show that psychiatrists are more likely to recommend commitment when examining patients within a hospital setting. *See* Babigian, Gardner, Miles and Romano, *Diagnostic Consistency and Change in a Follow-up Study of 1215 Patients*, 121 Am. J. Psychiat. 895, 897 (1965). Possibly, this is true because of the impact on the individual of confinement with persons who are seriously disturbed. *Cf. U.S. ex rel. Schuster* v. *Herold*, 410 F.2d 1071, 1078 (2nd Cir. 1969). In any event, a delay in the hearing until after confinement increases the likelihood of commitment.

In the instant case, the claim of entitlement to a precommitment hearing was raised by the plaintiffs, but rejected by the district court. No notice of appeal from this ruling was filed, so the question is not raised on this appeal. Any decision the Court should render on the merits, however, should reserve this issue for resolution in a case in which it is appropriately presented. The issue is raised in each of the cases in which amici are plaintiffs.

[52] National Institute of Mental Health, Statistical Note 90, Utilization of Psychiatric Facilities by Persons Under 18 Years of Age, U.S. 1971, Table I (1973). (Hereafter, "Stat. Note 90").

[53] *J. L.* v. *Parham*, 412 F.Supp. 141, 143 (M.D. Ga. 1976).



those receiving inpatient treatment are under eighteen years of age.[54] One out of every three of these children are now committed on an involuntary basis pursuant to an evidentiary hearing because their parents have objected to hospitalization.[55] Moreover, of the adults confined in state and county mental institutions, 53.9 percent have waived a hearing and committed themselves voluntarily[56] and, presumably, a substantial proportion of the children whose parents have consented would, after consultation with counsel, waive their hearings. Thus, the recognition of the hearing rights of children will result in only a minimal increase in the number of civil commitment hearings conducted. Indeed, as an erroneous commitment imposes a substantial unnecessary burden on the state in the form of costly inpatient care, an additional screening mechanism is likely to reduce overall costs to the state.

## B. Parents or Custodians Should Not Be Permitted to Waive a Child's Due Process Rights Incident to a Civil Commitment

In the preceding section, it is argued that due process requires the availability of counsel and an evidentiary hearing in connection with the commitment of a child to a mental institution. In apparent recognition of this, the law of every state guarantees a child whose parents do not consent to a commitment the same hearing

[54] Stat. Note 90.

[55] This calculation is based on nationwide data on state and county mental hospitals reported in National Institute of Mental Health, Statistical Note 105, Legal Status of Inpatient Admissions to State and County Mental Hospitals, U.S. 1972, Table 1a (1972). (Hereafter, "Stat. Note 105").

[56] This calculation is based on nationwide data reported in Stat. Note 105, Table Ia, *supra*.

rights accorded to adults. The sole ground on which children are denied a hearing is the consent or acquiescence of a parent or custodian. For several reasons, this is not a constitutionally adequate basis on which to deny the child's evidentiary hearing rights.

1. State Welfare Agencies Should Not Be Permitted to Waive a Child's Evidentiary Hearing Rights

It is important to emphasize at the outset that in many cases there is no parent involved in the decision to commit a child. In these cases, consent for the commitment is provided by the state welfare department, acting as guardian or "standing in loco parentis" to the child.[57] For example, in *Poe* v. *Mathews, supra,* twelve of the forty-eight "voluntary" juvenile patients on hospital rolls as of December 31, 1974 were committed as a result of applications filed by welfare agency officials.[58]. *See also* A. 311; *J.L.* v. *Parham, supra,* 412 F.Supp. at 132-33.

The generally asserted justification for the voluntary scheme—"the rights of parents to direct the upbringing of their children" (Pa. Br. at 30)—obviously does not apply to the commitment of children by state agencies. Welfare departments are not parents. They do not have toward their wards the emotional commitment a parent may be expected to have toward his child, and which may be thought to provide protection against arbitrary decisions. Welfare departments do not live with the children in their custody. They are not

[57] *See* statutes cited in note 5 *supra.*

[58] Defendants' Answer to Plaintiffs' First Interrogatories #26 (k).



knowledgeable as to their history or their emotional needs. They simply perform a placement function.

The court in *J. L.* v. *Parham, supra,* found that mental institutions are often used by state welfare agencies to dispose of difficult children for whom a suitable placement cannot readily be found. *J. L.* v. *Parham, supra,* 412 F.Supp. at 134-35.[59] A case in point is amicus J. R. In 1970, at the age of 7, he was placed in a state mental institution by the Georgia Department of Family and Children Services. *Id.,* at 116. Institutional officials have conceded since 1973 that J. R. does not need to be institutionalized, stating that he "will only regress if he does not get a suitable home placement, and as soon as possible." *Id.,* at 117. But J. R. was not re-

[59] The reasons for this were described by Dr. John P. Filley, Director of the Office of Child and Adolescent Mental Health Services, Atlanta, Georgia:

> The [welfare department] takes the child to the hospital and says, "Now, it's off our hands." They're beseiged with oversized case loads and so on . . . . [T]o take on the tough problem of a kid who's been through a period of hospitalization and is still not normal . . . it's going to take some extra work. And, to take it on at a time when they're already carrying 70 or 80 normal foster care cases is a high requirement on them.

*J. L.* v. *Parham, supra,* Deposition at 74. *See also Poe* v. *Mathews, supra,* Mess. Aff. at 9-10:

> Social agencies and child care institutions that request mental hospitalization of a juvenile are affected by different but equally significant institutional interests and pressures which can distort their judgment and result in inappropriate requests for hospitalization. The lack of adequate bed space for all those children assigned to the social agency, insufficient staff at particular times of the day or night, a paucity of psychiatric services at the social agency, and the bureaucratic tendency to reject those children who don't immediately conform to the required routines and schedules often culminate in an agency decision to transfer the troublesome or unwanted child to the mental hospital.

leased from the hospital until 1976, after the decision of the district court invalidating the state's commitment procedures.

Whatever rule may be applicable to the decision of natural parents to commit a child, it is clear that a state agency should not be permitted to authorize commitment of a child to a mental institution without the check provided by hearing procedures.

### 2. Parents Should Not Be Permitted to Waive a Child's Evidentiary Hearing Rights

But even when it is a parent who consents to the commitment, there are strong reasons not to treat this consent as dispensing with the necessity for the careful exploration of the appropriateness of confinement that an evidentiary hearing would allow.

#### a. *Circumstances Often Prevent Parents From Making an Informed Judgment as to the Suitability of Commitment*

Many parents who consent to commitment do so only because they believe there is no other alternative, not because they are convinced of the child's need for institutionalization. The commitment decision is usually preceded by a series of traumatic episodes which have placed the parents under a great mental strain. *See, e.g.*, A. 570-71, 588-90, 601, 616-17, 733-34. Parents are often unaware of the existence of or are unable to afford other treatment alternatives, such as an outpatient clinic or a private psychiatrist.[60] Thus, when they turn to the public mental institution for assistance and are advised by the institutional psychiatrist that their child needs to be institutionalized, they are in no position to determine otherwise.

[60] *See* Ellis, *supra*, 62 Calif. L. Rev. at 851-52.



The case of amicus Michael K. is illustrative. Michael was committed to Connecticut Valley Hospital under the Connecticut voluntary scheme. His parents consented to his commitment. At a preliminary hearing in *Martin M.* v. *Shepherd, supra,* Michael's father testified:

> Q. During the year Michael was [in the Hospital] did you, as his parent, feel that it was an appropriate place for him to be?
> A. No way, no way.
> Q. Why not?
> A. The conditions were deplorable.
> . . . .
> Q. Why did you sign him in the hospital?
> A. We had no other recourse, none.

Mr. Karl K., T. at 7.

Alternatively, a parental decision to seek commitment may result merely from failure in communication or honest differences in values.

> Parents may be confused, bewildered, and saddened by what they perceive as their child's "crazy" behavior. In individual cases there may be some validity to the parents' belief in a connection between acceptance of counter cultural styles and emotional difficulties, but parents' own visceral reaction to the different lifestyle may color their diagnosis. Where parental action does result in unjustified commitment, it is probably not due to malevolence or filial hatred but to a feeling more akin to irritation or embarrassment over the child's unconventional behavior. The level of irritation or embarrassment can become acute and reach a level where parents become desperate.

Ellis, *supra,* 62 Calif. L. Rev. at 851 (citations omitted); *see* B. Ennis & L. Siegel, The Rights of Mental

PATIENTS 38 (1973); *J. L.* v. *Parham, supra,* Mess. Dep. at 9.

b. *The Interests of the Parent May Not be Consistent With the Interests of the Child*

Statutes which permit a parent to commit a child without a hearing are based on the assumption that a parent will act consistent with his or her perception of the best interests of the child, and normally this will be the case. But, in many instances, as the court below determined, this is not the case.

> In deciding to institutionalize their children, parents . . . may at times be acting against the interests of their children.

A. 797-98.

Virtually every court that has considered the issue has found that with respect to the commitment of a child, there is a potential conflict between the interests of the parents and the interests of the child. *See, e.g., Heryford* v. *Parker,* 396 F.2d 393, 396 (10th Cir. 1968); *J. L.* v. *Parham, supra,* 412 F.Supp. at 133; *Saville* v. *Treadway,* 404 F.Supp. 430, 432 (M.D. Tenn. 1974); *New York Association for Retarded Children* v. *Rockefeller,* 357 F.Supp. 752, 762 (E.D.N.Y. 1973); *Horacek* v. *Exon,* 357 F.Supp. 71, 74 (D. Neb. 1973); *In re Henry G.,* 28 Cal. App. 3d 276, 285, 104 Cal. Rptr. 585, 591 (2nd Dist. 1972); *In re Lewis,* 51 Wash. 2d 193, 200-01, 316 P. 2d 907, 911 (1957); *In re Sippy,* 97 A.2d 455, 459 (Mun. Ct. App., D.C. 1953); *In re Wretlind,* 225 Minn. 554, 561-62, 32 N.W. 2d 161, 166-67 (1948).[61]

[61] The Chief Justice has advised of "the need to make civil commitment difficult, recognizing the dangers of relatives 'farming' out their kindred into mental institutions for motives not always worthy." *Kent* v. *United States,* 401 F.2d 408, 416 n.4 (D.C. Cir. 1968) (Burger J., dissenting).



The sources of this potential conflict are varied. In some instances the parent, for one reason or another, simply may not want to live with a difficult child. A case in point is amicus J. L. It was stipulated in the district court in *J. L.* v. *Parham* that this child was hospitalized because his mother was concerned that he was adversely affecting her relationship with her second husband and their child. Stipulation of Fact, Exhibit #2-B-2; Mess. Dep. at 44-46. Following her consent to J. L.'s commitment, she abandoned him and the institution thereafter was forced to deal with the state welfare agency in matters regarding J. L. 412 F.Supp. at 117. J. L. was confined at the Central State Hospital for more than five years, long after the hospital recommended his removal from confinement. *Id.* The district court found that this situation was not unique.

> Unfortunately, as the evidence indicates, there are some parents who abuse [the] authority [to commit] and who under the guise of admitting a child to a mental hospital actually abandon their child to the state. . . . [S]ome still look upon mental hospitals as a "dumping ground."

*Id.,* at 138.

But even when the conflicting interests are not so apparent, the basis for conflict exists. The emotional difficulties of children are almost always the result of a larger, more deep-seated family problem such as marital tension, financial uncertainty, or alcoholism. "Whenever there is a sick child, there is usually a sick family." *Id.,* Deposition of Dr. Wladyslaw Mazur at 9. Indeed, on many occasions it is because of the family's

"disinterest and inability to get along that the child gets sick." *Id.,* Deposition of Dr. James Craig at 11.

By focusing on the apparent pathology of the child, parents may be able to obscure the underlying problems and preserve the equilibrium of the family unit. A. 467-68, 471-72, 501, 588-89, 610, 668-69, 734.[62] This phenomenon is known as "scapegoating."

> From the point of view of the family, the primary function of scapegoating is that it permits the family to maintain its solidarity. . . . By focusing on one particular child, the families were able to encapsulate problems and anxieties which could potentially disrupt various family processes. There seemed to be an added solidarity between the parents who stood united against the problem child. The fact that it is a child who is disturbed permits the parents to continue to perform the tasks necessary for household maintenance.

Vogel and Bell, *The Emotionally Disturbed Child as the Family Scapegoat,* in A MODERN INTRODUCTION TO THE FAMILY 425 (rev. ed. 1968).

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[62] The decision to inquire about psychiatric help is always the outcome, to some degree, of a crisis in the family. . . . [The parents] may define the problem in terms of the child because they sense he threatens their psychic stability and their control over their anger. . . . They may suspect that it is they who need psychiatric help but come to get help for the child since he is the focal point of disturbance; he absorbs and reflects the conflicts in themselves.

THE MENNINGER FOUNDATION CHILDREN'S DIVISION, DISTURBED CHILDREN: EXAMINATION AND ASSESSMENT THROUGH TEAM PROCESS 23-24 (1969). *See* LAING AND ESTERSON, SANITY, MADNESS AND THE FAMILY (1964); Ellis, *supra,* at 860, 863; T. SZASZ, LAW, LIBERTY AND PSYCHIATRY 153-54 (1963); Chassen, Perelman and Weinberger, *Reducing Parental Resistance to Examination of Family Relationships: The Therapeutic Use of a Child Management Task,* 11 PSYCHOTHERAPY: THEORY, RESEARCH AND PRACTICE 387 (Winter 1974).



### c. *Parents Have Not Been Permitted Absolute Control Over The Rights of Their Children*

Last Term, in *Planned Parenthood of Central Missouri* v. *Danforth,* 428 U.S. ——, 44 U.S.L.W. 5197 (July 1, 1976), this Court held that a parent may not be granted an absolute veto over the decision of a minor child to secure an abortion. Perhaps even more significant to the decision in the instant case, in *Bellotti* v. *Baird,* 428 U.S. ——, 44 U.S.L.W. 5221 (July 1, 1976), the Court strongly indicated that a statute that permitted a child to obtain judicial approval for an abortion, where parental approval was withheld, would pass constitutional muster. Thus, the Court refused to uphold absolute parental control over a decision vital to the life of a minor, but implied that where there was disagreement, it could be properly resolved through a hearing procedure. That is exactly the result sought by plaintiffs here, in the context of a proposed civil commitment.

The decisions in *Danforth* and *Bellotti* are consistent with the historic rule that parents do not have unrestricted authority over the lives of their children. *See generally* 1 W. BLACKSTONE, COMMENTARIES *452-53, 460-66; 3 J. STORY, COMMENTARIES ON EQUITY JURISPRUDENCE, Chapter 34 (1835); J. WOERNER, A TREATISE ON THE AMERICAN LAW OF GUARDIANSHIP OF MINORS AND PERSONS OF UNSOUND MIND § 14 (1897). The law has long recognized that when the interests of children might conflict with those of their parents, independent representation for the children is required. *See, e.g., Prince* v. *Clark,* 81 Mich. 167, 170-71 (1890). Thus, courts have frequently appointed independent guardians for children and have refused to allow parents to

donate their children's organs;[63] alienate their children's property;[64] compromise their children's injury claims;[65] withhold non-essential medical treatment from their children;[66] and authorize the sterilization of their children.[67]

In *Prince* v. *Massachusetts,* 321 U.S 158 (1944), this Court pointed out that although "the custody, care and nurture of the child reside first in the parents," parental rights are not "beyond limitation." 321 U.S. at 166. Given the possibility for error and for basic conflicts of interests, this Court should not permit a parent to foreclose a child's right to be heard in connection with a decision as crucial to his life as commitment to a mental institution.

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[63] *See, e.g., In re Guardianship of Pescinski,* 67 Wis. 2d 4, 226 N.W. 2d 180 (1975); *Hart* v. *Brown,* 29 Conn. Sup. 368, 289 A. 2d 386 (1972); *Strunk* v. *Strunk,* 445 S. W. 2d 145 (Ky. 1969); *In re Richardson,* 284 So. 2d 185 (La. App.), *cert. denied,* 284 So. 2d 338 (S.Ct.La.1973).

[64] *See generally* 1 W. BLACKSTONE, COMMENTARIES *452-53, 465-66; 4 KENT, COMMENTARIES ON AMERICAN LAW 185-89 (1830); *see, e.g., Martorell* v. *Ochoa,* 276 F.99 (1st Cir. 1921); *In re Schulz Estate,* 374 Pa. 459, 98 A.2d 176 (1953).

[65] *See, e.g., American Mutual Liability Insurance Co.* v. *Volpe,* 284 F.75 (3rd Cir. 1922); *White* v. *Osborne,* 251 N.C. 56, 110 S.E. 2d 449 (1959); *Loesch* v. *Vassiliades,* 17 N.J. Super. 306, 86 A. 2d 14 (1952).

[66] *See, e.g., Jacobson* v. *Massachusetts,* 197 U.S. 11 (1944); *Green Appeal,* 448 Pa. 338, 292 A.2d 387 (1972), *appeal after remand,* 452 Pa. 373, 307 A.2d 658 (1973); *Re Sampson,* 65 Misc. 2d 658, 217 N.Y. S.2d 641 (Fam. Ct.), *aff'd,* 37 A.D. 2d 668, 323 N.Y.S. 2d 686 (1972); *Re Carstairs,* 115 N.Y.S. 2d 314 (Dom. Rel. Ct. 1952).

[67] *See, e.g., A.L.* v. *G.R.H.,* 325 N.E. 2d 501 (Ct. App. Ind. 1975); *In re NK.R.,* 515 S.W. 2d 470 (Mo. 1974); *Frazier* v. *Levi,* 440 S.W. 2d 393 (Civ. App. Tex. 1969).



It has been argued that hearings will disrupt the family relationship, but to paraphrase the words of this Court in *Danforth,* "[i]t is difficult . . . to conclude that providing a parent with absolute power" to commit a child to a mental institution over his objection "will serve to strengthen the family unit. Neither is it likely that such . . . power will enhance parental authority or control where the minor and the . . . parent are so fundamentally in conflict" and the parental effort to commit "already has fractured the family structure." 428 U.S. ——, 44 U.S.L.W. 5197, 5204 (July 1, 1976).

Indeed there is a substantial basis for the belief that affording a child a hearing right, where he disagrees with his parents' commitment decision, will enable parent and child to confront their differences openly, and may lessen the already existing conflict.

> This effort at fact finding itself would have a therapeutic effect on the child and family; for some it would be the first time they will have been exposed to all sides of the story. The end result would be to greatly reduce the trauma suffered by juveniles who are rushed through the present [procedure].

*Poe* v. *Mathews, supra,* Mess. Aff. at 14. *See also* E. GOFFMAN, ASYLUMS 140-41 (1961); *cf. In re Gault, supra,* 387 U.S. at 26; *In re Ballay, supra,* 482 F. 2d at 664.

## CONCLUSION

The judgment of the court below should be vacated, and the case dismissed as moot and for lack of standing. Alternatively, the case should be remanded to the district court for reconsideration in light of the changes in Pennsylvania law.

If the Court reaches the merits of this appeal, its decision should recognize the right of a child to counsel and an evidentiary hearing in connection with civil commitment sought by a parent or custodian.

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FOR ARGUMENT

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No. 75-1064

# In the Supreme Court of the United States

OCTOBER TERM, 1976

JACK B. KREMENS, ETC., ET AL., APPELLANTS

*v.*

KEVIN BARTLEY, ET AL.

*ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA*

## BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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# In the Supreme Court of the United States

OCTOBER TERM, 1976

No. 75–1064

JACK B. KREMENS, ETC., ET AL., APPELLANTS

*v.*

KEVIN BARTLEY, ET AL.

*ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA*

## BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

### QUESTIONS PRESENTED

The United States will discuss the following questions:

1. Whether the due process clause of the Fourteenth Amendment requires that procedural safeguards be afforded in the confining of juveniles to state mental health facilities.
2. If so, whether the parents of the juveniles may waive these safeguards on their behalf.
3. If they may not, whether due process is satisfied by the procedures required by the Commonwealth of Pennsylvania before juveniles may be confined to state mental health facilities on the initiative of their parents.

## INTEREST OF THE UNITED STATES[1]

The United States has an interest in the protection of both its young and its mentally handicapped citizens, who are the least able to represent themselves and to enforce their constitutional rights. In fiscal year 1976, an appropriation of $269,000 was approved by Congress for litigative efforts by the Department of Justice in these areas (Hearings on State, Justice, Commerce, the Judiciary, and Related Agencies—Fiscal Year 1977, before the Senate Committee on Appropriations, 94th Cong., 2d Sess. 595–596 (1976)).[2]

Large sums of federal money are also expended annually in the area of mental health care under such programs as the Community Mental Health Centers

[1] The United States participated as *amicus curiae* in the district court and filed a brief in support of the appellees.

[2] The United States has participated in various capacities in a number of other cases seeking to protect the constitutional rights of children and mentally handicapped persons. See *O'Connor* v. *Donaldson*, 422 U.S. 563 (letter submitted to the Court); *Morales* v. *Turman*, 535 F. 2d 864 (C.A. 5) (*amicus curiae*); *New York State Association for Retarded Children, Inc.* v. *Carey*, 393 F. Supp. 715 (E.D.N.Y.) (full participation in all aspects of the case, including discovery and argument; hereafter "litigating *amicus curiae*"); *Davis* v. *Watkins*, 384 F. Supp. 1196 (N.D. Ohio) (litigating *amicus curiae*); *Horacek and United States* v. *Exon*, No. CV 72–L–299 (plaintiff-intervenor); *North Carolina Association of Retarded Citizens and United States* v. *North Carolina*, C.A. 3050 (E.D.N.C.) (plaintiff-intervenor); *Halderman and United States* v. *Penhurst*, No. 74–1345 (E.D. Pa.) (plaintiff-intervenor); *United States* v. *Mattson*, decided September 27, 1976, No. 74–138 (D. Mont.), notice of appeal filed October 19, 1976; *Alexander and United States* v. *Hall*, C.A. No. 72–209 (D.S.C.) (plaintiff-intervenor); *United States* v. *Solomon*, decided July 8, 1976, C.A. No. 74–181 (D. Md.), appeal pending, No. 76–2184 (C.A. 4); *Gary W. and United States* v. *Stewart*, C.A. No. 74–2412–C (E.D. La.) (plaintiff-intervenor); *Stockton and United States* v. *Alabama Industrial School*, C.A. No. 2834–N (M.D. Ala.) (plaintiff-intervenor); *Rone and United States* v. *Fireman*, C.A. No. 75–355A (N.D. Ohio) (plaintiff-intervenor); *Jenkins* v. *Cowley*, C.A. No. 3–74–394–C (N.D. Tex.) (litigating *amicus curiae*); *Stamus and United States* v. *Leonhardt and State of Iowa*, C.A. No. 73–126–2 (S.D. Iowa) (plaintiff-intervenor); *Ewing* v. *Gaver*, C.A. No. C–74–147 (N.D. Ohio) (litigating *amicus curiae*); *Evans* v. *Washington*, C.A. No. 76–0293 (D. D.C.) (*amicus curiae*).



Act, 77 Stat. 290, as amended, 42 U.S.C. 2681 *et seq.*; Social Security Act, Sections 1801 *et seq.* (Medicare) and 1901 *et seq.* (Medicaid), as added, 79 Stat. 291, 343, 42 U.S.C. 1395 *et seq.* and 1396 *et seq.* These expenditures reflect the fact that the United States has an interest in the improvement of mental health facilities; it has a correlative interest in ensuring that people who do not require confinement are not committed to facilities from which people requiring inpatient treatment are, therefore, turned away. See S. Rep. No. 294, 90th Cong., 1st Sess. 3 (1967).

## STATEMENT

### *Procedural history*

This is a class action brought against state officials[3] in November 1972 on behalf of all persons eighteen years old or younger confined in Pennsylvania mental health facilities under the Pennsylvania Mental Health and Mental Retardation Act of 1966, 50 P.S.

[3] Appellants are the Director of the Haverford State Hospital, to whom applications for commitment and admission are made; the Secretary of Public Welfare of the Commonwealth of Pennsylvania, who enforces the Act and makes all necessary regulations; and the Deputy Secretary for Mental Health and Mental Retardation, who has general authority to supervise mental health facilities in Pennsylvania.

4402 and 4403. Respondents alleged that the statutes violated the due process and equal protection clauses of the Fourteenth Amendment by permitting commitment upon the application of a parent or guardian and without the procedural rights afforded adults. Each of the named plaintiffs had been committed or admitted to a state mental institution at his parents' request; none of the five wished to remain institutionalized. They sought declaratory and injunctive relief as well as damages.

A three-judge court was convened and, after receiving stipulations of fact and oral expert testimony, the court entered an opinion on July 24, 1975, holding the statutes violated due process. On November 17, 1975, the court entered an order enjoining the further confinement of juveniles committed against their will without a hearing and requiring the implementation of the procedures outlined in the court's opinion pending further action by the state legislature. No damages were awarded. This direct appeal followed.

*Facts*

At the time this suit was brought, the Pennsylvania Mental Health and Mental Retardation Act of 1966, 50 P.S. 4101 *et seq.*, provided a comprehensive scheme for mental health services in Pennsylvania. Sections 4402 and 4403 provided, respectively, for the voluntary admission and commitment of persons to mental health facilities. They provided that persons 18 years old and younger could be admitted or committed to a mental health facility upon the application of a parent or guardian and the concurrence of the director of the facility and could be released at the request of that parent or guardian. Adults (defined as anyone more than eighteen years old) may admit themselves and are free to withdraw at any time, in the case of voluntary admission, or within ten days after giving notice, in the case of voluntary commitment. No adult may be involuntarily confined without a court hearing, except in emergency situations.[4]



After plaintiffs filed this suit, the Department of Public Welfare adopted regulations providing certain procedural safeguards for children admitted or committed under Section 4402 or 4403. The regulations provide, *inter alia,* that all juveniles must be referred from a recognized therapist or physician who has psychiatrically evaluated the child; that the director of the institution must conduct an independent examination; and that within 24 hours after admission, every child who is at least thirteen years old must receive written notification explaining that he will be given periodic status reports on his condition, that he may contact his parents, and that he will be provided

[4] Section 4405 permits involuntary emergency detention for no more than 10 days. Section 4406 provides for involuntary commitment upon application to a state court after notice and hearing. Section 4404 permitted commitment upon application of third parties, without a hearing, but that section was held unconstitutional in *Dixon* v. *Attorney General of the Commonwealth of Pennsylvania*, 325 F. Supp. 966 (M.D. Pa) (consent decree). The court found Section 4404 "to be almost completely devoid of the due process of law required by the Fourteenth Amendment." 325 F. Supp. at 972.

with the telephone number of an attorney. If such a child objects to remaining in the institution, the director or the parent must institute an involuntary commitment proceeding or the child must be released.

On July 9, 1976, after this appeal was perfected and probable jurisdiction noted, Pennsylvania enacted the Mental Health Procedures Act.[5] The statute applies to the involuntary treatment of mentally ill, but not mentally retarded, persons,[6] and provides (Section 201):

> Any person 14 years of age or over who believes that he is in need of treatment and substantially understands the nature of voluntary commitment may submit himself to examination and treatment under this act, provided that the decision to do so is made voluntarily. A parent, guardian or person standing *in loco parentis* to a child less than 14 years of age may subject such child to examination and treatment under this act, and in so doing shall be deemed to be acting for the child. * * *

Thus, under the new act, persons who have reached fourteen are treated essentially as adults for purposes of voluntary commitment.[7] Persons under fourteen may still be admitted and withdrawn by their parents

[5] Appellees' Brief, pp. 2–5.

[6] Sections 103, 502.

[7] A minor over thirteen is treated differently in one respect: the director of the facility to whom application for commitment is made must notify such minor's parents or guardian of their right to a hearing within 72 hours by a judge or mental health review officer, "who shall determine whether or not the voluntary treatment is in the best interest of the minor" (Section 204).



or guardians.[8] In January 1977, the new act becomes applicable to persons previously subject to involuntary treatment.[9]

## SUMMARY OF ARGUMENT

Commitment to a mental institution involves such substantial interference with the liberty of any person, whether child or adult, that state commitment procedures must provide due process to be consistent with the Fourteenth Amendment. Although persons who voluntarily consent to commitment waive these procedural protections, the potential for conflict between the interests of parent and child is too great to permit the parent to waive the child's personal constitutional right.

To determine the procedures constitutionally necessary to permit commitment of a child to a mental institution, it is necessary to balance the interests involved. All three participants in the process—parent, child, and state—are concerned that those children, and only those, who need institutionalization be confined, and that the procedures by which this is accomplished be as efficient and as non-burdensome as possible. In addition, the child has an independent interest in liberty, and the parent has an independent interest in the unhampered exercise of his responsibility for his child. The risk that the current commitment procedures do not properly balance these inter-

[8] Sections 201, 206(b). In addition "any responsible party" may petition the appropriate state court for the release of a person under fourteen (Section 206(b)).

[9] Section 501.

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ests must be weighed against the probable effectiveness of alternative procedures in serving them. Although we agree with the district court's conclusion that the balance struck in the original Pennsylvania statute did not satisfy due process, we do not believe the record is sufficient to evaluate the constitutionality of the current statute.

## ARGUMENT

### I. NO PERSON MAY BE INVOLUNTARILY COMMITTED TO A MENTAL HEALTH INSTITUTION WITHOUT DUE PROCESS OF LAW

The Court has held that commitment proceedings, "whether denominated civil or criminal, are subject both to the Equal Protection Clause of the Fourteenth Amendment * * * and to the Due Process Clause." *Specht* v. *Patterson,* 386 U.S. 605, 608 (citation omitted). As Chief Justice Burger wrote in his concurring opinion in *O'Connor* v. *Donaldson,* 422 U.S. 563, 580, persons who are committed to mental institutions are deprived of their liberty:

> There can be no doubt that involuntary commitment to a mental hospital, like involuntary confinement of an individual for any reason, is a deprivation of liberty which the State cannot accomplish without due process of law. *Specht* v. *Patterson,* 386 U.S. 605, 608 (1967). Cf. *In re Gault,* 387 U.S. 1, 12–13 (1967). Commitment must be justified on the basis of a legitimate state interest, and the reasons for committing a particular individual must be established in an appropriate proceeding.

In addition, as the district court noted, the effects of commitment may last far beyond the period of



actual confinement, since some stigma is still attached to commitment for mental illness or retardation. See J.S. App. 34a, n. 8. Cf. *In re Ballay,* 482 F. 2d 648, 651–653 (C.A.D.C.).[10]

Children, like adults, enjoy the protections of the Fourteenth Amendment. *In re Gault,* 387 U.S. 1, 13. Although children, because of their dependence on their parents, do not enjoy the same degree of liberty as adults (see *Ginsberg* v. *New York,* 390 U.S. 629, 637–638), it does not follow that the state may provide for their involuntary incarceration without adequate procedural safeguards.[11] As the court of appeals held in *Heryford* v. *Parker,* 396 F. 2d 393, 396 (C.A. 10), a case involving commitment of a mentally deficient juvenile to a state training school,

> like *Gault,* and of utmost importance, we have a situation in which the liberty of an individual is at stake, and we think the reasoning in *Gault* emphatically applies. It matters not whether

[10] Courts of appeals have recognized the damage done to a person mistakenly placed in a mental hospital. See *In re Ballay, supra,* 482 F. 2d at 667; *Matthews* v. *Hardy,* 420 F. 2d 607 (C.A.D.C.); *United States ex rel. Schuster* v. *Herold,* 410 F. 2d 1071, 1078 (C.A. 2).

[11] Sections 4402 and 4403 are entitled "voluntary admission" and "voluntary commitment," respectively. But the procedures provided therein are voluntary only in the sense that they apply when parents or other guardians voluntarily admit or commit their children; no effect is given to the objections of the children being confined. Indeed, four of the five named plaintiffs alleged that they were initially confined against their wishes; none of the five wanted to remain at the time suit was brought, but, under the Pennsylvania statutes, they could not effect their own releases (App. 13a–16a).

> the proceedings be labelled "civil" or "criminal" or whether the subject matter be mental instability or juvenile delinquency. It is the likelihood of involuntary incarceration—whether for punishment as an adult for a crime, rehabilitation as a juvenile for delinquency, or treatment and training as a feeble-minded or mental incompetent—which commands observance of the constitutional safeguards of due process.

See also *Saville* v. *Treadway,* 404 F. Supp. 430, 432 (M.D. Tenn.); *J.L.* v. *Parham,* 412 F. Supp. 112, 136 (M.D. Ga.).

Appellants argue that a child has no independent right to challenge the decision of his parents that he should be committed to a mental institution, since, they suggest, that decision is not significantly different from the decision that the child should undergo treatment for a physical ailment (Brief, p. 36).[12] But we believe the differences in the two situations may indeed be significant. The greater long-term loss of freedom, the danger facing a healthy person who is erroneously confined to a mental institution, and the greater stigma attached to hospitalization for mental disorders require greater attendance to procedural safeguards. See *Morrissey* v. *Brewer,* 408 U.S. 471, 481. These considerations, plus the peculiar difficulties of diagnosis and prognosis in the field of mental disorders (including the difficulty in some circumstances of determining which member or members of a family, if any, are in need of treatment), strongly indicate the need for independent review of parents' decisions to confine their children to mental institutions. Cf. *Greenwood* v. *United States,* 350 U.S. 366, 375.

[12] Although we know of no case law suggesting that parents may not obtain treatment for physical ailments of their minor children against the wishes of the children, this Court has held that a state may not enforce a parental *veto* of a minor child's decision to have an abortion. See *Planned Parenthood of Central Missouri* v. *Danforth*, Nos. 74–1151 and 74–1419, decided July 1, 1976.



### II. A PARENT MAY NOT WAIVE THE PROCEDURAL PROTECTIONS TO WHICH HIS CHILD IS ENTITLED

In many situations, the law permits parents to make decisions for their children. When there is no substantial likelihood of a conflict of interest between the parent and child, it is reasonable to assume that the parent possesses and the child lacks the maturity and experience that responsible decision-making requires, and that the child's dependency on the parent makes it appropriate to rely on the parent's decisions. For example, in *Wisconsin* v. *Yoder,* 406 U.S. 205, the Court balanced the State's assertion of children's interest in compulsory formal education against the assertion by Amish parents of their interest and the interest of their children in exercising their religion. In that situation, the interest asserted by the parents prevailed. However, the Court in *Yoder* specifically distinguished that case from one involving potentially competing interests between parent and child (406 U.S. at 230, 233–234; footnote omitted:

> This case, of course, is not one in which any harm to the physical or mental health of the child or to the public safety, peace, order, or

welfare has been demonstrated or may be properly inferred. * * *

* * * * *

To be sure, the power of the parent, even when linked to a free exercise claim, may be subject to limitation under *Prince* [v. *Massachusetts,* 321 U.S. 158] if it appears that parental decisions will jeopardize the health or safety of the

* * * To be sure, the power of the parent, even when linked to a free exercise claim, may be subject to limitation under *Prince* [v. *Massachusetts,* 321 U.S. 158] if it appears that parental decisions will jeopardize the health or safety of the child, or have a potential for significant social burdens.

Here, in contrast, the district court concluded that "[i]n deciding to institutionalize their children, parents, as well as guardians ad litem or persons standing in loco parentis, may at times be acting against the interests of their children" (J.S. App. 36a–37a). The record here supports that conclusion. As one psychiatrist testified (testimony of Dr. Eli C. Messinger, App. 616a–617a):

> * * * I believe that there is widespread agreement in the field of psychiatry, as well as the other mental health professions, social work and psychology, that the problems of children and the problems of their parents are inextricably connected; that the family should be viewed in many instances as the locus of pathology or trouble; that it is impossible to understand the symptoms and behavior of any one member of the family without understanding its role in the family in maintaining the family equilibrium; that symptoms are often an expression, be it a distorted expression—a distorted attempt to communicate, make demands on, ask help from, seek the support of other members of the family.



Dr. Messinger also testified that in families that present a child for psychiatric treatment, often the parents or other family members are also in need of psychiatric care (App. 617a).

In these circumstances, the district court properly concluded that "parents may not effectively waive personal constitutional rights of their children" (J.S. App. 37a). Cf. *In re Gault, supra,* 387 U.S. at 55.

### III. THE ORIGINAL PENNSYLVANIA STATUTE DID NOT PROVIDE ADEQUATE PROCEDURAL PROTECTIONS

"Once it is determined that due process applies, the question remains what process is due." *Morrissey* v. *Brewer,* 408 U.S. 471, 481. Due process is not a mechanical concept which requires the same procedures in all situations. Rather, it is an adaptable, utilitarian requirement, the contours of which are determined by the particular needs and interests involved in particular situations. *Morrissey* v. *Brewer, supra; Cafeteria & Restaurant Workers Union* v. *McElroy,* 367 U.S. 886, 895.[13] This Court last Term summarized the

[13] While not determinative here, the due process standards promulgated in adult commitment and juvenile delinquency cases are instructive in deciding what process is due juveniles confined to mental health facilities, for the deprivation of liberty and the potential consequences are similar.

In the context of commitment of adults to mental health facilities, courts have held that due process requires an opportunity for a hearing on the need for confinement. See *In re Ballay,* 482 F. 2d

required analysis of the particular interests affected in any given case (*Mathews* v. *Eldridge*, 424 U.S. 319, 334–335):

> [O]ur prior decisions indicate that identification of the specific dictates of due process generally requires consideration of three distinct factors: first, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail. See, *e.g.*, *Goldberg* v. *Kelly*, [397 U.S. 254], at 263–271.

The private interests affected here are those of the child and of his parents: both are interested in assuring that a child who needs the treatment he can receive in a mental institution receives that help as promptly as possible, and without unnecessary potentially traumatic procedures. The child has, in addition, a discrete individual interest in not being unnecessarily institutionalized (cf. *In re Gault, supra*), and the parent has a discrete interest in freedom from state interference with his decisions regarding the custody

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648 (C.A.D.C.); *In re Barnard*, 455 F. 2d 1370 (C.A.D.C.); *United States ex rel McGurrin* v. *Shovlin*, 455 F. 2d 1278 (C.A. 3). In juvenile delinquency commitment proceedings, the juvenile is entitled to notice and a hearing with counsel, the right to confront and cross examine witnesses, and to remain silent. *In re Gault, supra.* He is not entitled to a jury. *McKeiver* v. *Pennsylvania*, 403 U.S. 528.



and control of his child (cf. *Wisconsin* v. *Yoder, supra*). These interests do not necessarily conflict with those of the state, namely, that those children, and only those, who require or will benefit from institutionalization are confined, and that the procedures by which this is accomplished are as efficient as possible. None of these interests is insignificant. Accordingly, due process requires that each be accommodated in the procedures adopted.

The second factor here is the risk that the current procedures permit the confinement of juveniles who do not require and will not benefit from institutionalization, and the probable value, if any, of specific additional procedural safeguards in minimizing that risk. Finally, the additional burden of the proposed supplementary procedures on the state's mental health and judicial systems must be considered.

It may well be that analysis of the juvenile commitment process in light of these factors would lead to the conclusion that the minimum constitutionally permissible procedures will vary in different situations. For example, it may be that some categories of infants or young children are so severely mentally defective, or suffer from such a clearly defined serious mental illness, that their suitability for institutionalization is as objectively recognizable and clinically demonstrable as a physical illness. In such cases, the risk of erroneous confinement might be minimal (particularly if appropriate categories were specified by statute or regulation), and due process might not require an independent further review of the medical decisions that are necessary for commitment pursuant to cur-

rent Pennsylvania Department of Public Welfare regulations (see *supra*, p. 5).

At the other extreme, due process may require a hearing equivalent to that provided for adults for the involuntary commitment of a juvenile mature enough to give effective consent to his confinement who does not suffer from a defect so serious as to prevent him from doing so. Cf. *Planned Parenthood* v. *Danforth, supra*, slip op. 21; *In re Gault, supra*, 387 U.S. at 55. In all other cases, it may be that due process requires at least that the child not be committed without an impartial determination (in addition to the certification by the parents' and committing institution's physicians) that such commitment is appropriate and consistent with his best interests.[14] That impartial determination need not be a judicial one.[15] In all cases, however, there would remain the further question of the availability of *habeas corpus*

[14] The need for an independent determination is highlighted by the fact that the statutory standards for commitment and admission are vague. Section 4102 defines "mental disability" as "any mental illness, mental impairment, mental retardation, or mental deficiency, which so lessens the capacity of a person to use his customary self-control, judgment and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under care as provided in this act. * * *"

[15] For example, an independent board of psychiatrists or other professionals might conduct an informal inquiry into the need for confinement and the possibility that treatment might be effected through less restrictive alternatives such as out-patient care or family counseling. See, *e.g.*, *Saville* v. *Treadway*, 404 F. Supp. 430, 438–439 (M.D. Tenn.), in which a three-judge court held unconstitutional Tennessee statutory provisions permitting parents to admit juveniles to mental health facilities. The court held that recommendations for admission must be reviewed by an independent board; hearings before the board were to be conducted in an informal manner.



or a similar procedure for later inquiry into the propriety of a continuing confinement. See *supra*, p. 6, n. 8.

It is, we submit, clear that the original Pennsylvania statute under consideration by the district court did not afford due process, since it made no distinctions in commitment procedures on the basis of the nature of the mental defect involved or the age of the juvenile. Instead, all persons less than ninteen years old were subject to confinement against their will, regardless of the nature of their mental defect, on the recommendation of their parent or guardian and the agreement of the director of the institution involved.

The statute enacted on July 9, 1976, does distinguish between the mentally ill and the mentally retarded, and between juveniles younger than fourteen and those who are older.[16] That statute, enacted after the district court's decision, was not considered by that court,[17] and the record here is therefore not adequate

[16] The enactment of the new statute does not moot this case, since commitments of children under age fourteen or for mental retardation are not affected by the new statute. Nor has the case been mooted by the fact that each of the five named plaintiffs is now at least nineteen years old. The case was duly certified as a class action pursuant to Fed. R. Civ. P. 23, the class consisting of all persons eighteen years of age or younger who have been, are, or may be admitted or committed to mental health facilities in Pennsylvania pursuant to the challenged statutes (App. 269a–270a). A controversy still exists between appellants and the present members of the class, and the issue in controversy is capable of repetition yet evading review. See *Board of School Commissioners of the City of Indianapolis* v. *Jacobs*, 420 U.S. 128, 129 (per curiam); *Sosna* v. *Iowa*, 410 U.S. 393, 397–402.

[17] Nor did the court specifically analyze the procedural safeguards contained in the Pennsylvania Department of Public Wel-

to permit this Court to make the detailed analysis necessary to determine whether it affords due process, or, if not, what additional procedures are now necessary. Accordingly, we suggest that the case be remanded to the district court for consideration of whether the subsequently enacted statute meets due process requirements.[18]

## CONCLUSION

For the foregoing reasons, the case should be remanded to the district court for further proceedings consistent with this Court's opinion.

Respectfully submitted.

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fare's recent regulations implementing the original act (see J.S. App. 25a, n. 5). Those regulations require the referral of all juveniles to be admitted to a state mental institution by "a recognized medical facility Mental Health/Mental Retardation therapist or Mental Health Agency * * * [or, in the case of mental defectives, by a] pediatrician, or general physician, or psychologist" (Appellants' brief, p. 12).

[18] If the district court concludes after such review that the new act is constitutionally inadequate in particular respects, it would, in our view, be proper for it to adopt affirmative remedial measures on an interim basis, pending the necessary changes in state legislation or regulations to correct the deficiencies. Cf. *Brown* v. *Board of Education*, 349 U.S. 294 (*Brown*).

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